THE MANAGEMENT OF MENTALLY ILL DETAINEES IN THE CORRECTIONAL SYSTEM: A COMPARATIVE STUDY

by

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The Management of Mentally Ill Detainees in the Correctional System: A Comparative Study

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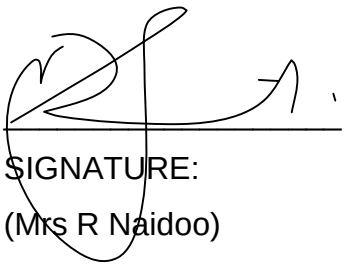

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(Mrs R Naidoo)

DEDICATION

This thesis is dedicated to:-

- God who has granted me the will to complete this study, never ceasing to be, and still is, my pillar of strength.

- My beloved mother and father, who although having already left the world left us a legacy of self-development and unconditional love.

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SUMMARY

There are approximately 5 million mentally ill detainees across the globe and a further 1 million who suffer from a severe mental illness. Various research has shown that the prevalence of mental illness within the corrections system is more substantive than that of the general population. On average, there is an upsurge by 1 million mentally ill detainees globally per year. Approximately all detainees detained in a correctional facility encounter depression or stress symptoms, however low rates of identification and treatment prevail. Further to this, the quality of the treatment provided to mentally ill offenders is questionable.

The aim of the research study is to explore the prevalence of mental illness amongst detainees in South Africa, Nigeria, Germany, and the United States of America. The study investigates the availability of legislation in all four countries using the various international guidelines as a benchmark, the provisioning of rehabilitation programmes, and the challenges in providing rehabilitation, mental health care, and treatment to the mentally ill. Furthermore, the study sets out to ascertain whether the treatment and conditions in detention facilities meet international standards.

Whilst considering that not all mentally ill offenders will need specialist psychiatric treatment, differing levels of care should be available on a continuous basis by personnel who are adequately proficient in reducing mental harm and in promoting mental health among offenders.

Recommendations include the need to conduct wider-scale national studies to make for easier comparisons and for benchmarking purposes. The availability of mental health legislation in itself is not a panacea for reducing mental health illness, but having to put this into practice is of paramount importance. The corrections system is at the end of the value chain and does not have a choice of closing their doors to offenders. They therefore need to partner with various government departments (criminal justice system, social systems, education systems, and community

structures amongst others), to find an integration point to share knowledge and insight into the challenges facing corrections and for the Criminal Justice System to acknowledge that severely mentally ill individuals should never be sent to corrections.

Key Terms: *mental illness, mental health, detainees, prisoners, offenders, corrections, mental capacity, rehabilitation, treatment*

OPSOMMING

Daar is ongeveer 5 miljoen sielsieke aangehoudenes wêreldwyd en ’n verdere 1 miljoen wat aan ’n ernstige geestesversteuring ly. Navorsing toon dat die voorkoms van geestesversteuring in die korrektiewe stelsel meer substantief as by die algemene bevolking is. Daar is jaarliks ’n gemiddelde styging van 1 miljoen sielsieke aangehoudenes wêreldwyd. Feitlik alle aangehoudenes in ’n korrektiewe fasiliteit ervaar simptome van depressie of stres, maar die syfers ten opsigte van identifisering en behandeling is laag. Die gehalte van die behandeling wat sielsieke oortreders ontvang, is boonop twyfelagtig.

Die oogmerk van hierdie navorsing was om die voorkoms van geestesversteuring onder aangehoudenes in Suid-Afrika, Nigerië, Duitsland en die Verenigde State van Amerika te ondersoek. Die studie het ondersoek ingestel na die beskikbaarheid van wetgewing in al vier die lande, met behulp van die verskillende internasionale riglyne as ’n maatstaf, die voorsiening van rehabilitasieprogramme en die uitdagings wat met die voorsiening van rehabilitasie, geestesgesondheidsorg en behandeling van die geestesiekes gepaardgaan. Die studie het ook ten doel gehad om te bepaal of die behandeling en toestande in aanhoudingsfasiliteite aan internasionale standaarde voldoen.

Met inagneming daarvan dat nie alle sielsieke gevangenes spesialis- psigiatriese behandeling benodig nie, moet verskillende vlakke van sorg deurlopend beskikbaar gestel word deur bekwame personeel wat oor die vermoë beskik om geesteskade te verminder en om gevangenes se geestesgesondheid te bevorder.

Aanbevelings sluit die behoefte in om studies op ’n groter skaal landswyd uit te voer vir doeleindes van makliker vergelykings en vir normstelling. Hoewel die beskikbaarheid van wetgewing oor geestesgesondheid nie opsigself ’n wondermiddel is vir die vermindering van geestesversteuring nie, is dit uiters noodsaaklik dat die wetgewing in plek moet wees. Die korrektiewe stelsel is aan die einde van die waardeketting, dus is dit nie ’n opsie om hul deure vir oortreders te sluit nie. Hulle moet dus met verskeie staatsdepartemente

(onder andere, strafregsplegingstelsel, maatskaplike stelsels, opvoedingstelsels en gemeenskapstrukture) saamspan om ’n integrasiepunt te vind om kennis en insig rakende die uitdagings wat die korrektiewe stelsel in die gesig staar te deel, en sodat die strafregsplegingstelsel sal erken dat individue met ernstige geestesversteurings nooit na korrektiewe fasiliteite gestuur moet word nie.

Sleutelterme: *geestesversteuring, geestesgesondheid, aangehoudenes, gevangenes, oortreders, korrektiewe fasiliteite, verstandelike vermoë, rehabilitasie, behandeling*

ISIFINYEZO (ISAMARI)

Kukhona abantu abacishe babengu 5 miliyoni abagula ngengqondo abavalelwe kuwo wonke umhlaba, kanti kukhona abanye abangu 1 miliyoni abahlushwa yisifo sengqondo. Ucwaningo lukhombise ukuthi ubukhona besifo sengqondo kwinqubo yezamajele bukhulu kakhulu ukudlula kwisizwe sonkana ngokunabile. Ngokwesilingniso, kukhona ukwenyuka kwabantu abagula ngengqondo abavalelwe abangu 1 miliyoni kuwo wonke umhlaba ngonyaka. Cishe bonke abantu abavalelwe ezindawo zamajele babanokuxineka kwengqondo noma izimpawu zingcindezi, kodwa izinga lokuphawulwa kwabo kanye nokuthola ukwelashwa liphansi. Kanti futhi okunye, iqophelo lokwelashwa elihlinzekwa abantu abonile abagula ngengqondo alilihle.

Inhloso yalesi sifundo socwaningo, bekuwukuphenya ngobukhona bokugula ngengqondo kubantu abavalelwe eNingizimu Afrika, eNigeria, eGermany nase-United States of America. Ucwaningo luphenyisise ngobukhona bemithetho kuwo womane amazwe ngokusebenzisa imikhombandlela kazwelonke njenge-benchmark, ukuhlinzekwa kwezinhlelo zokwelapha kanye nezinselele ezikhona ngokuhlinzeka ngokwelapha, unakekelo lwezempilo yengqondo kanye nokwelashwa kwabagula ngengqondo. Kanti futhi okunye, ucwaningo belufuna ukuqinisekisa ukuthi ngabe ukwelashwa nezimo ezikhona ezindaweni zokuvalelwa emajele kuhlangabezana namazinga amazwe omhlaba.

Ngisho noma kubonelelwa ukuthi akuyibo bonke ababoshiwe abagula ngengqondo abadinga ukwelashwa ngokwengqondo kwezinga le-psychiatric, kodwa amazinga ehlukene onakekelo, kumele atholakale ngokuqhubekela phambili okunikezwa ngabantu abanolwazi nekhono ngokufanele ekuphunguleni ukulimala kwengqondo kanye nokuqhubekisela phambili impilo yezengqondo kwababoshiwe

Izincomo zibandakanya isidingo sokwenza ucwaningo olunabile kumazwe ukwenzela ukuthi kubelula ukuqhathanisa kanye nenhloso yokwenza i-benchmarking. Ubukhona bemithetho yonakekelo lwempilo yengqondo akusona isixazululo sakho konke

ngokuphungula ukugula ngengqondo, kodwa ukuba nemithetho esebenzayo kubaluleke kakhulu. Inqubo yezamajele isekugcineni, kanti ayinalo ukhetho lokuvala iminyango kubantu ababoshiwe. Ngakho-ke izikhungo zababoshiwe kumele zisebenzisane neminyango ehlukene kahulumeni (inqubo yezobulingiswa yamajele, izinqubo zenhlalakahle yabantu, izinqubo zemfundo kanye nezakhiwo zemiphakathi, phakathi kokunye) ukuthola indawo ehlangene yokwabelana ngolwazi mayelana nezinselele amajele abhekane nazo kanye nenqubo yezobulungisa yamajele ukwamukela ukuthi abantu abagula kakhulu ngengqondo akumele bathunyelwe emajele.

Amathemu abalulekile: *ukugula ngengqondo, impilo yezengqondo, abafakwe emajele, iziboshwa, abonile, ukuqondisa izimilo, ikhono lezengqondo, ukuhlengwa, ukwelashwa*

KAKARETŠO

Go na le bagolegwa ba ka bago 5 milione bao ba lwalago ka monaganong lefaseng ka bophara le ba bangwe ba 1 milione ba ba nago ba lwalago kudu ka monaganong. Dinyakišišo di bontšhitše gore go ata ga malwetši a monagano ka gare ga tshepedišo ya ditshokollo go bohlokwa kudu go feta ka gare ga setšhaba ka kakaretšo. Ka kakaretšo, go na le koketšego ya bagolegwa bao ba lwalago ka monaganong ba 1 milione lefaseng ka bophara ka ngwaga. Ba e ka bago bagolegwa ka moka bao ba golegilwego lefelong la tshokollo ba itemogela kgatelelo ya monagano goba dika tša kgatelelo, eupša dikelo tša boitšhupo le boitshwaro le kalafo di fase. Go feta mo, boleng bja kalafo ye e fiwago basenyi ba ba lwalago ka monaganong bo a belaetša.

Maikemišetšo a dinyakišišo tše e be e le go utolla go ata ga bolwetši bja monagano gare ga bagolegwa ka Afrika Borwa, Nigeria, Germany le United States of America. Dinyakišišo di nyakišišitše go hwetšagala ga melao dinageng ka moka tše nne go šomišwa ditlhahli tša go fapafapana tša boditšhabatšhaba bjalo ka motheo, kabelo ya mananeo a tsošološo le ditlhohlo tša go abela tshokollo, tlhokomelo ya maphelo a monagano le kalafo go bao ba lwalago ka monaganong. Go feta moo, dinyakišišo di ile tša ikemišetša go netefatša gore kalafo le maemo a dikgolego a fihlelela maemo a boditšhabatšhaba.

Ge re ntše re nagana gore ga se bagolegwa fela ka moka bao ba lwalago ka monaganong ba tla hloka kalafo ye e kgethegilelego ya malwetši a monagano, tlhokomelo ye e fapanego e swanetše go hwetšagala ka mo go tšwelago pele ke bahlankedi ba ba nago le bokgoni bjo bo lekanego bja go fokotša dikotsi tša monagano le go tšwetša pele maphelo a monagano gare ga bagolegwa.

Ditigelo di akaretša tlhokego ya go dira dinyakišišo tše di tseneletšego tša setšhaba go dira dipapišo tše bonolo le bakeng sa merero ya go bea maemo. Go hwetšagala ga molao wa maphelo a monagano ka bowona ga se pheko ya go fokotša malwetši a mongano, eupša go šomiša molao wo ke selo se bohlokwa kudu. Tshepedišo ya

ditshokollo e mafelelong a tatelano ya tshepedišo gomme ga e na kgetho ya go tswalelela basenyi ka ntle. Ka gona ba hloka go šomišana le dikgoro tša go fapafapana tša mmušo (tshepedišo ya toka go bosenyi, ditshepedišo tša leago, ditshepedišo tša thuto le dikarolo tša setšhaba, gare ga tše dingwe) go humana ntlha ya kopanyo go abelana tsebo le temošo ditlhohlong tše di lebanego le ditshokollo bakeng sa tshepedišo ya toka go bosenyi go amogela gore batho bao ba lwalago kudu ka monaganong le gatee ga ba swanela go romelwa ditshokollong

Mareo a bohlokwa: *bolwetši bja monagano, maphelo a monagano, bagolegwa, babofša, basenyi, ditshokollo, bokgoni bja monagano, tshwaollo, boitshwaro*

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

According to the World Health Organisation's press release at the Geneva Conference held on 4 October 2017, there are close to 450 million people who presently suffer from mental or neurological disorders (World Health Organisation, 2005). With the current worldwide emphasis on mental health, even so with the escalated levels arising from the COVID-19 pandemic, major depression, post-traumatic stress disorder, and anxiety disorders were found to be the most common disorders (Mari & Oquendo, 2020:219).

McKenna, Skipworth and Pillai (2017:3) indicated that there are in excess of 10 million detainees in penal institutions around the world and according to Blaauw and Van Marle (2007:133), half the world's inacrcerated population suffer with personality disorders and approximately one million detainees are ill with serious mental disorders.

Research by Adams & Ferrandino (2008:913) has shown that there is disparity in the standards of treatment and care offered in corrections as compared to that which is provided in the community. It is therefore imperative for corrections health care and public health care to work closely to find a plausible solution to closing the evident gaps (Adams & Ferrandino, 2008:913; Møller, Stöver, Jürgens, Gatherer & Nikogosian, 2007:10) in public health programmes, including community-based programmes and corrections rehabilitation programmes. Programmes must focus on risk factors as well as give emphasis to educational development, skills development, employability, "interpersonal relationships, drug and alcohol treatment, mental health care and cognitive- behavioural interventions" amongst others (United Nations Office on Drugs and Crime, 2018:9).

Constitutions of the world oblige corrections to treat and care for detainees who suffer with severe medical and psychiatric conditions, yet, according to the Lancet Commission Report on Mental Health and Sustainable Development, human rights defilements of mentally ill detainees continue to exist (Pillay, 2019:464). This sadly remains the situation in many countries, despite being aware that the numbers of mentally ill are to increase drastically and their mental condition is bound to worsen "exponentially" with incarceration (Denysschen, 2018).

One of the ultimate aims of the corrections system is to reduce recidivism and socially integrate detainees through its efforts of rehabilitating and reforming them. Decreasing recidivism, however, remains a yardstick in measuring the success of criminal justice systems throughout the world (United Nations Office on Drugs and Crime, 2018:4). The rates of recidivism among mentally ill detainees are high, in some instances higher than 70%, but interventions specially intended to meet the psychiatric and social needs of mentally ill detainees are said to reduce recidivism (Morgan, Flora, Kroner, Mills, Varghese & Steffan 2012:38-39).

1.2 BACKGROUND

Nothing can be truer than the message implied in a quote from Sir Winston Churchill: "Healthy citizens are the greatest asset any country can have" (Naik, 2016). Countries worldwide have strived for a healthy population with the realisation that a healthy population is the backbone to economic stability. Husain (2010:35) argues that although the above may be true, specific efforts such as providing superior and more reachable health services, introducing innovative medicines and modern technology in health, and encouraging healthier behaviours have led to positive changes in the health of a population.

The Esidimeni tragedy that claimed the lives of 144 mentally ill patients in Gauteng shook the health fraternity in South Africa (Life Healthcare Esidimeni Scandal, [sa]). Makgoba (2017:18) found that these mental patients died under unlawful circumstances. These circumstances included the findings that the patients were cared for by unlicensed Non-Governmental Organisations (NGOs) and the patients were sent to NGOs against the policy framework for gradually

downscaling institutionalisation. In a statement issued by the South African Council of Churches (2017) it was iterated that there was gross negligence on the part of the NGOs who took the responsibility of caring for these patients who were transferred from the Department of Health. A decision made by the former Member of the Executive Council, Qedani Mahlangu, to enter into a contract between the Department of Health and Life Esidimeni for Life Esidimeni to care for the mentally ill set the ball rolling for the debacle that ensued (The Life Esidimeni Case, [sa]). Despite a public outcry, the decision was implemented with dire consequences that found the Department of Health at the centre of litigations and investigations into the disregard for the human rights of the mentally ill.

The Criminal Justice System therefore cannot afford to turn a blind eye to the challenges faced by community based services. These challenges and limitations must be taken into consideration when a decision is being taken on the placements of mentally ill persons. Correctional facilities too are underresourced and face numerous challenges such as overcrowding, inappropriate facilties, insufficient professional staff and insufficient budgets to actualise the obligations of international law which places the responsibility on Governments to ensure that human rights and the wellbeing of detainees are protected (Lehmann, 2012:131).

One such instrument being 'The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)' (The United Nations, 2015). Rule 1 makes provision for the treatment of all detainees with the respect due to their inherent dignity and value as human beings. It also makes provision for authorities to ensure equivalent standards of health care as obtained in the community (The United Nations, 2015:8), and for access to essential health care by detainees at no cost to them and without discrimination (Rule 24:8). Further to this, health care professionals are prohibited to ill-treat detainees (Rule 32 (1)(d) and places an obligation on them to report cases which they may become aware of (Rule 34:11).

Rule 92, in particular, obliges one to consider the specific needs of all those in detention including the most "vulnerable categories" as well as the safeguarding and the advancement of the rights of detainees with special needs. Detainees

must be regarded as a vulnerable population for severe mental disorder (Norbert & Opitz-Welke, 2014:517). Health establishments must work closely with the criminal justice system in order to ensure that it comes to the management of mentally ill persons.

1.3 THE RATIONALE OF THE INVESTIGATION

Since the Esidimeni tragedy every institution which detains mentally ill persons, be it a governmental or non-governmental institution, must focus on their legislations, policies, and operations to ensure that they are not found wanting. Research by Coldefy (2012:4); Finzen (2015); Konrad & Opitz-Welke (2014:517); Leping, Steinert, Gebhardt & Röttgers (2004:94) and Robertson, Janse van Rensburg, Talatala, Chambers, Sunkel, Patel & Stevenson (2018:362) related to deinstitutionalisation has emphasised how mentally ill detainees are managed within the corrections system. This investigation is based on such research to gain insight into the management of mentally ill detainees in the correctional systems of four countries, namely, South Africa, Nigeria, Germany, and the United States of America (USA).

1.4 SIGNIFICANCE OF THE STUDY

A change in legislation in the form of Criminal Procedure Amendment Act 4 of 2017 brought an amendment to the Criminal Procedure Act 51 of 1977 and which has necessitated the Department of Correctional Services (DCS) to develop a circular to all officials to amend operating procedures to effect this change. The change was, that involuntary mental health care users must not be admitted into the DCS system but be detained in a designated mental health establishment (Republic of South Africa, 2017a:4).

During threats and risk assessments conducted in 2018 at various DCS facilities by the DCS Security Standards team, a common theme that arose was that there were no “appropriate” personnel in the employ of some facilities to manage mentally ill remand detainees (Naidoo, 2018). The Inspecting Judge of Correctional Services, Justice Johann van der Westhuizen, during his visit to

Upington Correctional Centre found that officials were not trained to detect and manage mentally ill detainees and this led to violence by detainees against officials and "inappropriate" reaction by officials (Judicial Inspectorate for Correctional Services, 2018:33). Research on the management of mentally ill detainees in the corrections system would clarify and gain insight into the type/kind of personnel required to "handle" mentally ill detainees.

Regardless of the "type" of personnel required to manage the mentally ill in corrections, the researcher wanted to determine the role that civil society plays in the improvement to the mental health care of detainees. This would also help to uncover whether NGOs are at a stage where proper care could be taken of the mentally ill that the DCS could possibly release out to the community. This begs to answer the question whether community-based care has progressed to an extent that it could take on the responsibility of providing acceptable standards for the treatment and care of mentally ill patients. Further to this, it would be helpful to know whether deinstitutionalisation would result in thrusting the mentally ill into a malicious cycle of destitution and criminality (Stevenson, 2017).

1.5 RESEARCH PROBLEM

It is the primary responsibility of the Department of Health to care for the mentally ill, according to the South African Law as emulated in the Criminal Procedure Act, 51 of 1997. However, provision is made that the DCS can also take responsibility for the mentally ill who are in conflict with the law. Studies by Prinsloo (2013) and Naidoo and Mkhize (2012) have shown that the South African correctional system is not equipped to handle mentally ill detainees.

The Nigerian Lunacy Act (1958) did not specify the mental health institution as being that of public health or that of the criminal justice system. These "lunatics" were mistreated as criminals and many found their way into detention (Ude, 2015:2). The Nigerian Prison Services faces challenges such as overcrowding, dilapidated facilities, and abuse of human rights against the mentally ill (Opafunso & Adepoju, 2016:2).

Whilst in Germany, persons who are mentally ill and found guilty of a crime would be sent to a forensic psychiatric treatment unit in terms of Section 63 of the German Criminal Code (Federal Republic of Germany, 2010:24) and if a sentence to imprisonment is added to this then the detainee must be treated first (Federal Republic of Germany, 2010:26). Section 67(2) of the German Criminal Code indicates that in the case of a sentence of three years and more, a part of the sentence can be served first if it makes for better administration (Federal Republic of Germany, 2010:26). Salize, Dreßing and Kief (2007:155) found that care and treatment in German detention facilities differs from one state to another.

Detainees in the USA have a constitutional right to health care through the Eighth Amendment's prohibition of "cruel and unusual punishment", yet their access to adequate health care is limited (Wilper, Woolhandler, Boyd, Lasser, McCormick, Bor & Himmelstein, 2009:666). The most frequent violation found in finding letters issued to jails for constitutional violations by the Department of Justice was related to health care standards (Mellow, Peterson & Kim, 2016:80). This can be attributed to the overcrowding of state and federal detention facilities' ineffective rehabilitative programmes, insufficient resources and lower staff to detainee ratios (O'Connor, 2014:49; Turner, 2008:412). A high percentage of detainees with chronic medical issues do not even get medically examined whilst in detention (68 percent of local jail detainees, 20 percent of state detainees, and 14 percent of federal detainees) (Vallas, 2016:10). This not only worsens the existing health and mental problems but also creates an environment for detainees to contract further health and mental health problems (Vallas, 2016:11).

Research therefore indicates that corrections are ill equipped to provide the necessary services it should (Adams & Ferrandino, 2008:924; Galanek, 2015; Sukeri, Betancourt, Emsley, Nagdee & Erlacher, 2016).

1.6 AIMS AND OBJECTIVES OF THE STUDY

If the Life Esidimeni tragedy has been caused by the social, political, or justice structures, as alluded to by Murphy (2017:1), then this would require one to question the contribution of the Government in South Africa, and indeed that of all

Governments, in ensuring that the most vulnerable in society are given the dignity and respect they deserve. The researcher therefore explored the role of Government in the health care of their mentally ill citizens in terms of Government's moral and legal duty to do so.

Further to this the researcher explored the role of the corrections systems in the management of mentally ill detainees, and specifically, the Department of Correctional Services of South Africa, Prison Administration in Germany, the Nigerian Prison System, and that of the United States of America. Adams and Ferrandino (2008:913), in their study, concluded that a substantial number of detainees require mental health care in the United States of America. Correctional officers play various roles in the correctional environment, and caring for these mentally ill patients poses a challenge to correctional officials, as they do not only concentrate on one role in the corrections environment (Adams & Ferrandino, 2008:923). They try to manage their administrative roles against that of treatment concerns of the mentally ill detainees (Fazel & Danesh, 2002:546). The researcher thus explored the role of the corrections officer in the caring of mentally ill detainees.

The first study that measured psychiatric illness of South African detainees was conducted by Naidoo and Mkhize in 2010 at the Durban Westville Correctional facility. Amongst the findings was a high rate of psychiatric disorders amongst detainees. 23% of "prisoners" had mental disorders. 46% of sentenced detainees had antisocial personality disorders. It was further found that differences existed on the number of detainees' prevalence rate of mental disorders, as diagnosed in the study, compared to those receiving treatment (Naidoo & Mkhize, 2012:33). This then begs the question as to whether the corrections system has sufficient policies to address such anomalies.

This documentary study would be insufficiently addressed if a comparative analysis on the management of mentally ill detainees was not done. The researcher thus conducted a comparative analysis of correctional systems in South Africa, Nigeria, Germany, and the USA. There must be meaningful insight gained into how other countries cope with mentally ill detainees. This comparison

was conducted with the aim of having to improve the management of such a population. The researcher chose Germany because its rehabilitation of mentally ill is regarded as one of the best in the world (Subramanian & Shames, 2013:12). Thus an opportunity to benchmark against Germany. The USA was chosen because the focus on rehabilitation had diminished from the 1970's onwards (Phelps, 2011:33). This could be a warning sign to South Africa's rehabilitative efforts. According to Ude (2015:5) Nigeria did not consider the rehabilitation of mentally ill detainees. The researcher needed to understand the reasons for this so that South Africa as an African country could strengthen their rehabilitation efforts within an African context.

Before sending an accused for temporary detention (whether for a bed for observation, or to wait for the availability of a bed in a psychiatric hospital), courts must consider the detrimental effects of detention on the mental state of individuals (Melamed, 2010:100; Republic of South Africa, 2017a). According to the World Health Organisation (2005:75), the conditions in detention lend themselves to mental ill health. There are many negative factors that can worsen the condition of those who are mentally ill (Adams & Ferrandino, 2008:923; Srivastava & Tiwari, 2012:66). Amongst these are the lack of resources to properly administer treatment, being in a confined environment, lack of privacy, and isolation from loved ones. The researcher aimed to open up debates by policy makers to explore alternatives to the incarceration of mentally ill persons.

In order to achieve the aforementioned aims, the following objectives were formulated to:

- Understand and compare legislations of South Africa, Nigeria, Germany, and the United States of America mandating corrections to commit a mentally ill person under its care.
- Understand the role of corrections in the CJS.
- Understand the management of mentally ill detainees in corrections
- Understand the challenges facing corrections in the management of mentally ill detainees.

- Propose a model for South Africa for the management of mentally ill detainees in a correctional system.

1.6.1 Research Questions

Willig (2013:20) indicates that a research question focuses the researcher's attention on the particular phenomenon they wish to investigate and spurs the researcher to act and to put processes in place (e.g. How does Correctional Services manage mentally ill detainees?). Qualitative research requires that questions be crafted at a descriptive level and be used merely to identify the phenomenon (e.g. How are mentally ill detainees managed from a corrections' perspective?) and not to propose an explanation that necessitates testing against reality (e.g. 'To what extent do non-governmental organisations support the efforts of corrections management to cope with the mentally ill detainees?).

The researcher therefore tried to find answers to the following questions:

- Which legislation gives corrections the mandate to commit a mentally ill person under its care?
- What is the role of corrections in the Criminal Justice System?
- What are the challenges being faced by corrections in promoting the human rights of detainees with regard to mental health?

1.7 THE RESEARCH APPROACH

1.7.1 The Research Design

A research design is a plan which logically guides and outlines the collection of data, the measurement of the data, and an indication of how data would be analysed in order to effectively address the research problem and answer the research questions (Salkind, 2010:1253) in such a manner that it obliterates ambiguousness as well as providing the methods for generating, locating, and assessing evidence as indicated by Perecman and Curran (2006:181).

The researcher has, for the purposes of this research chosen a documentary research approach. Data was attained by reviewing literature related to the study on mental illness among the detainee population.

1.7.2 Qualitative Research Approach

Qualitative research is used “to describe and possibly explain events and experiences, but never to predict. Instead, they ask questions” (Willig, 2013:52). According to Willig (2013:53), one needs a knowledge of theory to interpret data.

According to Sandelowski (2001:230), numbers are integral to qualitative research as they establish the importance of a research project, they document that which is known about the problem, numbers are used to describe a sample and generate meaning from qualitative data. The researcher thus used numerical information such as prevalence of mental illness among the detainee population, ranking of incarcerated populations, percentages of remand detainees, incarcerated populations in relation to the total population, and quoting numerical information from the various studies conducted, amongst others.

The researcher chose to include numerical data for purposes of this research because the numerical data allowed the researcher to determine the magnitude of mental illness among detainees and to understand themes around mental illness. This would assist in informed decision making and effective planning around mental illness therefore the need for one to know figures and current trends.

Factors that influenced the choice of research methodology included and were not limited to ethicality of the research, as well as the suitability of the method used (Rajasekar, Philominathan & Chinnathambi, 2013:12).

1.7.2.1 Whether the research is ethical or not

The research was ethical as the mentally ill patients were not the target population. The researcher conducted a content analysis research methodology of legislation and policies that pertain to the management of mentally ill detainees.

1.7.2.2 Whether the method is suitable

“Prisoners are regarded as closed institutions and documents provide important insights into the activities of such institutions” (Noaks & Wincup, 2011:6). The researcher gained access to documents, first-hand information on the treatment of detainees, and to statistics that were available in the public domain (published and publicly presented documents), newspapers, magazines, journals, and official documents. The researcher also included administrative documents, presentations to executive/management, references to meetings, visits, and books. According to Scott and Marshall (2009) researchers would find such documentation of value. Noaks and Wincup (2011:6) indicate that documents in the form of internal and external oversight reports and other official documents provide a “plethora of detailed information”.

Researchers who use documentary sources do this to find out about specific issues (Noaks & Wincup, 2011:8). In this research documents were used to gain insight into the management of mentally ill detainees in the corrections system with regard to the legislation, policies, and standing operating procedures that govern this. Further to this, the researcher addressed the roles of the correctional officers and oversight bodies (if any). Oversight bodies included Non-Governmental Organisations.

The researcher used documentary sources and opted for a desktop study to gain an insight into the provisioning of programmes to mentally ill detainees, the care of mentally ill detainees, and the challenges facing corrections in the management of mentally ill detainees. This method is suitable because it allowed for the researcher to gain insight into the management of mentally ill detainees.

1.7.3 Data Collection Methods

The researcher reviewed and analysed existing documents. The current research is a content analysis of legislation and policies in the criminal justice systems of South Africa, Nigeria, Germany, and the USA as it relates to identifying issues around mentally ill detainees. The specific aspects that were examined were the

history and theory of correctional systems in each country, current developments with regard to the legislation and policies governing the management of mentally ill detainees, legislation as it pertains to detainees' mental health within the human rights framework, sentencing of the mentally ill, correlates to crime, the management of mental illness within the human rights criminal capacity, the admission screening processes, assessments of mentally ill detainees, rehabilitation, and challenges being experienced in the management of mentally ill detainees.

1.7.3.1 Documentary research

According to Scott and Marshall (2009:188), documentary research includes "research that uses public and official documents as a source material". These sources for research can be in the form of newspapers as well as publications by government on their statistics, photographs, and institution's policies amongst others (Gibson & Brown, 2009:74; Noaks & Wincup, 2011:106).

When one is considering research in the criminal justice field one should be mindful of the fact that research involving legislation analysis is embedded in politics. Public health researchers must take into account the impact of political ideologies on influencing public policy, making it necessary to be aware of how this can have an impact on policy implementation (Bernier & Clavier, 2011:109-110). Taking this into consideration the researcher must be in a position to access political speeches and statements, manifestos, and if possible official reports of parliamentary proceedings (Noaks & Wincup: 2011:11).

One can determine the priorities that an institution has from analysing their annual official publications, their strategic plans, and their governing legislations, amongst others. As an example, one would be able to see whether corrections are prioritising security as opposed to rehabilitation and care of detainees. One can also see the trends over time e.g. has there been an increased focus on mental health or not (Noaks & Wincup, 2011:12). The advantage of using documentary research is that the researcher remains objective in the process (Bohnsack, 2014:31).

Gaining access to information directly from personnel working in corrections may not be easy. Thus, the use of documents may be easier to access than the personnel themselves. Suffice to say that even legislation changes/reports or executive summaries from high profile politicians may be easier to access from institutional documents.

According to Louw (2008:10), existing data, either collecting it or using it is advantageous. Existing data is practical in the sense that it is less costly than other methods such as field research, it is unobtrusive, and it is reliable and valid. It is also argued that the value of documents must be thoroughly assessed according to four criteria before they can be used. These criteria are: authenticity, credibility, representativeness, and meaning (Kridel, [sa]; Viswambharan & Kumar, 2015:13).

Data was attained primarily from a literature search and the review of various studies conducted on corrections as they related to the mentally ill. The following sources of information included: books, reports from various international organisations such as the World Health Organisation, the Central Intelligence Agency, World Prison Brief, the United Nations Office on Drugs and Crime, the United Nations, Penal Reform International, international conventions and treaties, local, regional, and international journals, reports from commissions, government legislation, policies, and respective Acts, web-based information, newspaper articles, national and international data obtained from the Department of Prisons/Corrections as the case may be.

Further to this, the researcher searched a wide variety of electronic databases to identify issues surrounding mental illness among the incarcerated populations in South Africa, Germany, Nigeria, and the USA. Information on mental illness in detention facilities was very hard to come by, and because mental illness in corrections expands over multi-disciplines all major related databases were searched. The following databases were searched for studies dating from 2000 to current: African Journals Online (all disciplines but narrowed down to psychology, psychiatry, social), Cochrane Reviews, Directory of Open Access Journals, EBSCO (UNISA searches), Google Scholar, Hein Online (law), JSTOR, National

Criminal Justice (Criminology), Project Muse (Social Science), ProQuest, PsycINFO (Psychology), PsychNet (Psychology), PubMed (BioMedical, psychology), PubPsych (Psychology), Researchgate, SAGE (Social Sciences), ScienceDirect (medicine, science) and LexisNexis. There were no date limits placed on the searches because the researcher conducted historical developments in the countries studied as well as current developments with regard to the legislations on mental health. In addition to these reasons, was the fact that databases are continually enhanced and digitised journal articles are constantly uploaded. Further to this, with the advent of the COVID-19 pandemic, the researcher thought it would be best to include this aspect in the discussions.

1.7.3.2 Authenticity

The documents used by the researcher were assessed for authenticity. The researcher ensured that the documents used were genuine and the origin of the documents was assessed for collective or institutional authorship (Rajasekar et al., 2013:38). If the document was altered/amended the researcher acknowledged this fact.

Relevant qualitative policy material, articles, and studies from researchers out of the country were obtained via the contact details for full articles by the authors, via websites or e-mail, as well as obtaining information from the corrections' websites and government websites which allowed browsing and downloading from their websites. All information on the website was read. Where appropriate health/mental health information was found, it was downloaded. Further to this, e-resources from the University of South Africa were extremely helpful in obtaining the appropriate journal articles and e-books.

1.7.3.3 Credibility

Credibility refers to the accuracy and honesty of documents. To determine how accurate a report is one must look at the conditions under which it was written, as well as the credibility of the source/s (Rajasekar et al, 2013:19). In this study, documents that were produced in meetings and other gatherings which were not

in the public domain were not included. The use of these would have jeopardised the credibility of the information.

1.7.3.4 Representativeness

The documents used needed to be representative of all the relevant documents and available for researchers to use. Usually in security institutions such as corrections, document accessibility may be controlled as documents in many state departments are classified in terms of their secrecy level and their confidentiality. The researcher looked at the applicable legislation governing the management of mentally ill detainees, relevant policies and procedures that were and are being developed so that a holistic view of the management of mentally ill detainees could be given.

The legislations and policies examined were representative of all four countries stated in the study. Electronic searches using Google included using a combination of relevant search terms for each country's name, together with the following terms: Department of Corrections, Department of Prisons, mental health legislation, mental health policy, mental health screening, recidivism, sentencing of mentally ill detainees.

1.7.3.5 Meaning

Documents must be readable (in a language that is understandable) by its users. All searches were done for literature in English as it is the home language of the researcher. Legislation pertaining to Germany was in German and not in English. This was however overcome by obtaining the relevant literature from the studying institution. The evidence in the document needed to be clear and comprehensible (Kridel, [sa]) and the researcher questioned whether the document used was appropriate to its historical, social, and cultural context.

As a researcher it is important to familiarise oneself with the historical context of a policy. This enables one to gain an understanding of the social issue/problem as it was experienced in the past to help make better decisions for the current

situation and the future (Ude, 2015:2). This is something that the researcher considered when the policies and procedures of South Africa, Nigeria, Germany, and the USA were analysed to determine the effectiveness in managing mental illness.

1.8 ETHICAL CONSIDERATIONS

In this qualitative documentary research study, the researcher applied for ethical clearance from the University of South Africa's Research Ethics Committee. The researcher obtained permission from the DCS to conduct research within their organisation.

Research does not always involve collection of data from the participants. A huge amount of data is collected through other surveys and research activities. However, there are certain ethical issues pertaining to secondary data analysis which were taken care of (Tripathy, 2013:1478).

Data must be de-identified in a manner where **c**onsideration is given to preventing someone's personal identity from being revealed. Secondary data vary in terms of the amount of identifying information in it and researchers should take care that the data is not linked to personal information of study participants (Tripathy, 2013:1478). The data used by the researcher did not have any identifying information of the study participants (such as names, street address, licence numbers, identity numbers, photographs, video of participants, transcripts of interviews, biometrics or any other unique identifiers) and therefore could not be linked to any individual participant.

Further to this, the data was freely available on the internet, books, journals and in other public forums. Therefore permission for further use and analysis is implied (Tripathy, 2013:1478). Consent of study participants can be reasonably presumed The researcher acknowledged the ownership of data used in the various studies and there was no need for the researcher to re-identify participants.

There was no personal research conducted with participants in this research and therefore there would not be any potential harm to individual subjects or distress caused to any participant. The findings from research and surveys already conducted was used to support arguments and staments in this research.

1.9 DELIMITATION OF THE STUDY

The Criminal Procedure Amendment Act 4 of 2017 (Republic of South Africa, 2017a) was approved on 29 June 2017. This brought a change in the accommodation of Involuntary Mental Health Care Users (IMHCUs). IMHCUs could, prior to this amendment, be detained in DCS facilities as prescribed by the Criminal Procedure Act 51 of 1977. This has since been amended and states that IMHCUs are to be admitted in a designated health establishment. The DCS engaged with the National Department of Health for the appropriate and suitable placements of the involuntary mental health care users that were already in the Department of Correctional Services facilities. No new admissions were accepted by the Department of Correctional Services. This research therefore did not include current information on IMHCUs in the South African correctional system.

The generalisation of the prevalence of serious mental disorders could not be extended to the whole South African corrections scenario as there are very limited studies conducted on this. Generalisation was limited to one study conducted by Naidoo and Mkhize in 2009. The study concluded that the high prevalence of mental disorders found was "in keeping with the significant high rates internationally" and that the corrections systems do not detect a large number of detainees with mental disorders (Lotter, 2014).

1.10 DEFINITION OF KEY CONCEPTS

1.10.1 Annual Performance Plan

A single year plan that links the activities of a department in response to the long-term strategic goals found in Government Departments (financial years start from

1 April to 31 March in South Africa) (Department of Planning, Monitoring and Evaluation, [Sa]:3-4).

1.10.2 Assisted mental care user

A mentally ill individual who is not able to decide on admission and treatment because of his/her mental illness, but who gives consent to receive care, treatment, and rehabilitation (Department of Health, 2013:6).

1.10.3 Asylum

For purposes of this study, this term is used to denote a facility used in some countries including Nigeria to accommodate the mentally ill.

1.10.4 Capital Crime

Refers to a crime for which the punishment is death (Macmillan Law Dictionary, 2020).

1.10.5 Community Mental Health Teams (CMHT)

Community mental health teams provide care for the mentally ill within their own homes or 'homely settings' in the community and not in institutional settings. They are usually a multi-disciplinary team of nurses, occupational therapists, psychiatrists, psychologists, and social workers (Malone, Marriott, Newton-Howes, Simmonds, & Tyrer, 2007:1).

1.10.6 Correctional Centre, Remand Detention Facility, Prison, or Detention Facility

A place for accommodating persons sent by court through a legal warrant for the person's detention. It also includes the building and land used for such purposes. Note in terms of Section 86(a) of the Correctional Services Amendment Act 25 of 2008, the word "prison" was incorrectly used within a South African context and

should be substituted with the word “correctional centre” respectively. Prison is used in other countries.

1.10.7 Detainee, offender, or inmate

For purposes of this research study a detainee will refer to a person who has an order from court to be detained under the corrections system of a country and will be used interchangeably with the words offender, and inmate. They will refer to all persons detained, incarcerated, or imprisoned. The terms detained, incarcerated, or imprisoned too will be used interchangeably. The context in which these words are used will be clear when discussing each country.

1.10.8 Felony misdemeanour

Felonies are the most serious crimes that one can commit and those who commit a felony usually get long sentences of one year or longer or to life imprisonment without parole or even death. They include murder, rape, burglary, kidnapping, and arson (FindLaw, 2019a).

Misdemeanour is a less serious crime which warrants short sentences – usually less than a year. E.g. if you drink and drive – it is regarded as a misdemeanour but if you drink and drive with children in the car this is a felony (FindLaw, 2019a).

1.10.9 Health Care in DCS

Refers to outpatient and inpatient care for all medical issues (medical care, dental, mental, acute and chronic care) and provided by registered health care professionals (Department of Correctional Services, 2000:3).

1.10.10 Human Rights

Refers to the rudimentary levels of treatment that government is obliged to provide to all of its population without any form of discrimination (Smith & Hattery, 2007:279).

1.10.11 Involuntary Mental Health Care User (IMHCU)

Refers to a person who is seriously mentally ill and does not have the ability or has impaired ability to make informed choices. He/she refuses treatment but the law allows that they be sent for compulsory admission to a mental health facility for treatment (Department of Health, 2013:7).

1.10.12 Mental Health

A state of wellbeing in which an individual can realise his/her own potential, cope with the normal stresses of life, work productively and make a contribution to the community (World Health Organization, 2005:7).

1.10.13 Mental Illness

It refers to a diagnosed mental problem in line with approved criteria, that affects the feeling, thinking, and behaviour of individuals towards other people (National Alliance on Mental Health, 2020; Republic of South Africa, 2002:6). These problems become clinical and a degree of professional intervention and treatment is required.

1.10.14 Mentally Ill Person

Means a person who because of a mental illness is not able to take decisions regarding his state of affairs and therefore needs care and treatment (Duhaime's Law Dictionary, sa).

1.10.15 Observation Case

Refers to a person who is accused of a crime but did not have the capability of understanding the events in court to defend him/herself and is sent to a correctional centre/remand detention facility through an order by court to await a forensic enquiry (Houidi, Paruk & Sartorius, 2018:1).

1.10.16 Official Document

These refer to documents produced by the respective institutions responsible for the corrections and can be in the form of publications on their statistics and institution's policies amongst others (Gibson & Brown, 2009:74; Noaks & Wincup, 2011:106).

1.10.17 Prison, correctional centre, or correctional facility

In this study, the word 'prison' has been used for all places of detention under the corrections or prison system (Coyle, 2009:10). The context in which these words are used will become clear when discussing each country e.g. South Africa only uses the words 'correctional centre' or 'correctional facility' and 'corrections system'.

1.10.18 Psychiatric Hospital

Means a health facility that is responsible to care for, treat, and rehabilitate users with mental illness (Republic of South Africa, 2002:12). A forensic psychiatric hospital is therefore a secured facility providing the same services but accommodates persons accused of a crime (Sukeri et al., 2016:1)

1.10.19 Remand detainee or awaiting trial

For purposes of this research study, a remand detainee will mean the same as an awaiting trial/pre-trial detainee, and refers to all those who are accused of a crime and are detained in a correctional facility whose trial has not commenced, those who have been convicted and are awaiting sentencing or extradition, and those whose trials are on-going (Department of Correctional Services, 2014b:29).

1.10.20 State Patient

Refers to a person who is mentally ill who committed a serious offence and who has been ordered by court to be detained in a corrections facility due to

unavailability of beds at a designated institution (Department of Justice and Constitutional Development, 2016:4).

1.10.21 Recidivism, re-lapse, re-offending, re-conviction rate, re-arrest, re-imprisonment and re-incarceration

These words describe an offender who has been imprisoned more than once (Abuchi, 2015:1)

1.10.22 Region vs. Provinces

South Africa consist of nine provinces, namely, KwaZulu Natal, Gauteng, Limpopo, Eastern Cape, Mpumalanga, Northern Cape, North West, Western Cape, and Free State Provinces. The Department of Correctional Services administrates over six regions. Three provinces, namely, Limpopo, Mpumalanga and North West are combined to form one region called the Limpopo, Mpumalanga and North West Region. Similarly, two provinces, namely, the Free State and Northern Cape Provinces are combined to form the Free State Northern Cape Region.

1.10.23 Solitary Confinement

This refers to the imprisonment of detainees in single cells for 22 to 24 hours a day with no contact or extremely limited contact with any person (Conley, 2013:418).

1.11 PROPOSED OUTLINE OF CHAPTERS

Chapter 1: Introduction to the Study

This chapter consists of the introduction which contextualised the research problem in terms of the Esidimeni tragedy. A discussion of the rationale for undertaking the study and the significance of the study is included. The research approach is detailed in this chapter and included the research design, qualitative

research approach, the research problem, the research question, and data collection methods. It is followed by a summary of the literature review of the management of mentally ill detainees in South Africa, Nigeria, Germany, and the USA.

Chapter 2: Historical Development of the Management of Mentally Ill Detainees

In this chapter, the researcher reviews the literature on transformation in detention management. The discussions progress to the management of the mentally ill becoming clients of the Criminal Justice System.

Chapter 3: Mentally Ill Detainees within the Criminal Justice System

In Chapter 3, the researcher documents the legislation/legal framework and policies that govern the management of the mentally ill in the Criminal Justice System of the countries being studied. A comparison of the organisations of corrections in the different countries is given.

Chapter 4: Mental Health Care and Human Rights

Chapter 4 outlines health care and the human rights issues surrounding the management of mental health care in the general population in each country being studied. There are specific references made to how the mentally ill are managed.

Chapter 5: Mental Illness in the Detainee Population

This chapter provides information on the mentally ill detainee population in South Africa, Nigeria, Germany, and the USA. Statistical information is provided on sentencing, the numbers of mentally ill detainees, as well as correlates to crime.

Chapter 6: Mental Health Services in Corrections

In this chapter, the researcher outlines the rehabilitation programmes and services

available in each country for mentally ill detainees. The role of the correctional official/guard is outlined, and the challenges for the implementation of rehabilitation programmes are also discussed. Thereafter, the requirements and processes of eligibility for parole/release are discussed.

Chapter 7: Findings and Recommendations

In this chapter, a summary of the findings is given and based on the findings of the study, recommendations are made for the management of mentally ill detainees.

1.12 CONCLUSION

The mentally ill detainees in any country deserve the right to be treated with humanness and to be properly cared for. The role played by the government and in particular the Criminal Justice System is crucial in the proper application of just, fair, and equitable laws that should cater for this vulnerable population. This does not end just with the availability of legislation, but the implementation thereof is critical to avoid the dumping of mentally ill in detention facilities that do not have the resources to manage them. The role of corrections is imperative to ensure that the conditions under which this population is detained necessitates special consideration for their mental illness which inadvertently leads to the generation of better management of the mentally ill.

The aim of this research was to analyse the management of mentally ill detainees from a corrections perspective in four countries namely, South Africa, Nigeria, Germany, and the USA. This was done through an analysis of legislation, policies, procedures, and attitudes of all role-players in the corrections system, with regard to the management of mentally ill detainees.

CHAPTER 2

HISTORICAL DEVELOPMENT OF THE MANAGEMENT OF MENTALLY ILL DETAINEES

2.1 INTRODUCTION

The Criminal Justice System (CJS) represents the whole range of government agencies, bodies, groups, and/or institutions, which functions as a mechanism of the state to put into effect its established rules which are essential for social cohesion and compliance with the law. These include, but are not limited to, law enforcement, courts (adjudication and trial), corrections (probation and parole), oversight bodies, professional bodies such as academia, mental heath and forensic services. The CJS aims to uphold the rights of the citizens. The CJS provides legal provisions and procedures by which a citizen can seek justice, appropriate compensation and redressal in case of the violation of his/her rights (Olonisakin et al., 2017:33-34).

Ukwayi and Okpa (2017:19) report that gaining access to justice is an indispensable part of any criminal justice system. Access to justice in most countries necessitates sufficient legitimate backing and justifiable continuance in the apportionment of justice. Ukwayi and Okpa (2017:19) go on further to state that it is unfortunate that the last echelon of the criminal justice system, namely corrections, is subjected to the ineffectiveness of the system to which it belongs. There is, therefore, a need to unpack the criminal justice system before understanding the development of the correctional system in each of the countries being studied namely, South Africa, Germany, Nigeria, and the United States of America.

On examining documented history, one commonly comes across references to early detention facilities being utilised for the confinement of religious and political detainees. It is quite impossible to ascertain the exact date of the general beginning of imprisonment as a punishment for crime, because detention facilities evolved due to the needs and whims of those in power, and it may be earnestly

doubted if such a date exists (Barnes, 1921:36). Thus, the researcher attempted to understand the evolution of detention from biblical times through to the “modern” corrections establishment.

2.2 BIBLICAL BACKGROUND OF MENTALLY ILL

Mentally ill persons are usually ostracised by society and not meant to be taken seriously. This was no different even during biblical times. The negativity associated with being mentally ill is depicted when King Achish states “Behold, you see the man behaving as a madman. Why do you bring him to me?” (Samuel 21:12-14: Holy Bible New Kings Version). This boldly shows that society did not want to be associated with the insane. In John 10:20 (Holy Bible New Kings Version) people are informed that Jesus is mad, and some Jews are questioned as to why they listen to Him.

Being mentally ill is regarded as a curse in the Bible. This is clearly seen in Deuteronomy 28:28 (Holy Bible New Kings Version) when blessings would be bestowed on the obedient and curses of “madness, blindness and bewilderment of heart" to the non-obedient. When “God” conquered the armies who attacked Israel, he did so by cursing them with insanity so that they began to slaughter each other in a “psychotic panic of delusion”.

Further to this, the Bible clearly illustrates that mentally ill persons belong in confinement as is stated in Jeremiah that "every man who is demented put him in prison and in the stocks and some with an iron collar around his neck”. This explains that from the very beginnings it was regarded a crime for one to be mentally ill and as such, belonged in detention. The command to shackle the demented insinuates that mentally ill persons are dangerous and should be treated inhumanely (like animals).

2.3 ROLE PLAYERS IN THE CRIMINAL JUSTICE SYSTEM

It is the duty of every government to combat crime and the process and system of doing this is called the Criminal Justice System (Adeosun, 2018). The criminal

justice system (CJS) is a critical element of any country to ensure that justice and neutrality is applied in practising the rule of law. The CJS serves to institutionalise and imprint the political systems of a country.

The three branches of government, namely, the executive branch, legislature, and the judiciary, provide the elementary structure for criminal justice in the countries studied. The legislature creates laws that regulate actions or behaviour that is contrary to the law and it determines penalties for crime. In addition to this, the legislature governs the rules for criminal procedure. The courts infer and interpret the law and determine whether it meets statutory requirements, whilst the executive arm of government plans long term goals, programs and strategies, appoints personnel, and exercises administrative responsibility for the CJS (Stephens, 2018:19).

Bentham and Beccaria (1995, as cited in Harcourt, 2013:2-5) believed that the main manner in which the criminal justice system adds to the contentment of society is by ensuring its safety through its efforts of keeping crime under control. Crime tends to cause harm and reduce the amount of happiness in society. It can therefore be deduced, that if punishments reduced the amount of crime they enhanced the amount of happiness. Bentham (2001, as cited in Harcourt, 2013:8) propounded that this happiness is at its greatest when the individual is absorbed into a society as a law-abiding citizen. Their belief that happiness truly exists when it is equally distributed within all community members (Harcourt, 2013:7). Therefore, the conclusion is drawn that the degree of societal happiness will determine whether society will accept the CJS as being effective or not.

Bentham and Beccaria (1995, as cited in Harcourt, 2013:8) both critically assessed the abusing and dehumanising effect of punishment metered out in excess and recognised negligible deterrence as a restrictive principle on punishment. They both favoured certain punishment for certain crimes and added that administering of punishment as soon as possible after guilt is determined is a way to “strengthen the associations of punishment with crime” (Harcourt, 2013:5).

The acceptance of the criminal justice system by its community members depends on their experiences of the CJS. Such experiences in turn will affect behaviour towards the CJS, and because human beings interact with one another, this behaviour towards the CJS can be replicated by other community members. Personnel involved in the governing and administering of the structure is a crucial element in every criminal justice system (Olonisakin et al., 2017:32). In the event that the process of influencing others is flawed (corrupt), then such influence may become either undesirable, challenging to achieve and, or, met with absolute contempt and disregard (Baron & Branscombe, 2012:263-264). Therefore, in persuading, exerting influence, and ensuring compliance, the agents of influence in the CJS must be credible and be consistent in applying the rule of law (Olonisakin et al., 2017:33-34; Wood, 2000:541-546). Credibility is associated with fairness, justice, equality, effectiveness, and efficiency.

Plaatjies (2005:124) argues that the criminal justice system is not a legal system. Ukwayi and Okpa (2017:18) further elaborate, stating that the CJS is a tool of the state used against individuals' deeds that are contradictory to the established standards and rule of law. Despite the many interpretations of the CJS being a legal system or not, it is established that the criminal justice is a system which is made up of a set of legal, penal, and societal establishments for operationalising criminal law (Frase & Weidner, 2018; Olonisakin et al., 2017:33-34). Bentham and Beccaria both agreed on the need for formal law, and 'legality' gives legitimacy to the criminal justice system" (Harcourt, 2013:5).

A system can also be seen as a set of main beliefs or processes, according to which something is done, usually in an organised manner. Criminal justice systems thereby operate in accordance with a distinctive set of procedures with limitations, and because all of the institutions in the CJS are highly inter-reliant, it stresses the need for overall planning, co-ordination and structure. The different role-players of the system interact with each other in complex ways and what each role-player does should be contingent on what the other role-players do. Changes brought about in one part of the system can have major impact on the rest of the parts (Frase & Weidner, 2018). Ukwayi and Okpa, (2017:125) on the other hand, argue that although the different parts of the CJS are reliant on one another, they

are not necessarily dependent on each other, and may even have conflicting goals. The police, who have an objective to apprehend more suspects in line with their targets which increase annually due to increased criminal activity, will be in conflict with the goals of the courts. Courts may decide not to prosecute, and this will therefore be counter-productive to the police goals (Olonisakin et al., 2017:33-34; Stephens, 2018:15). With society calling for stricter and harsher punishments for wrongdoing, the courts give in to the pressure to prosecute as many as possible, which will ultimately lead to more detainees being sent to correctional facilities. Such institutions are already overcrowded and overcrowding is counter-productive to the rehabilitation goal of the correctional system.

The police are charged with the responsibility of preventing, combating, and investigating crime in order to uphold civil safety, safeguard the inhabitants of a country, protect and secure property, and to uphold and administer the law. They are also in authority to construct a harmless and protected environment and to avert anything that may become a threat to the security or safety of the public. Their jobs include guaranteeing that criminals are “brought to justice” as well as to investigate and deal with the causes of crime (Department of South African Police Service, 2015:2; Stephens, 2018:20).

The courts are part of the judicial branch of any government. The judiciary has an important role in the CJS by ensuring that it safeguards and protects the Constitution of the country. It has to epitomise the Constitution’s values in ensuring that the administration of justice is applied in a manner that realises a better life for all. While the police start the process of a criminal proceeding, the courts are there to guarantee that all processes and factors are considered in handing out justice. The court determines the guilt or innocence of persons brought “before her” and metes out adequate and appropriate punishment (Olonisakin et al., 2017:36). But it is the presiding officers who are “fact finders” and who hear the cases and ensure that the rule of law is adhered to. They are tasked with handing down a judgement to the criminal. The prosecutor works with the state and has to prove the culpability/guilt of an accused person (Stephens, 2018:20).

Corrections are primarily responsible to maintain and implement sentences of the judge. Correctional services also contribute to upholding the laws and good order of society and to protect society by keeping those who have violated the law away from society. In their primary role to enforce sentences of the courts and to legally detain all inmates, corrections all over the world have been finding ways to detain inmates within a humane environment. Recent developments in correctional planning and approaches have included a rehabilitative role for detainees.

One can therefore conclude that the CJS is a system of the different consecutive stages through which detainees pass from their first contact with the law to “final disposition” and is made up of the various interrelated agencies and institutions responsible for administering the law, and working towards a shared goal of addressing crime in the country in order ensure the safety of its people (Stephens, 2018:14).

The discussion that follows will focus in detail on the CJS of South Africa, Germany, Nigeria, and the United States of America.

2.4 SOUTH AFRICA

2.4.1 The South African Criminal Justice System

The South African Criminal Justice System is based on a highly politicised system (Plaatjies, 2005:158). Its administrative capital is in Pretoria. Cape Town houses its legislative capital, and Bloemfontein seats its judicial capital. The judicial system is accountable for legislation and puts into force most criminal laws that fall on the national legislature and the national infrastructure of courts, political, and community structures.

Racial discrimination was rife in South Africa and has been clearly legislated in the administration of justice. The country's racial laws which emphasised white racial superiority, together with colonialism, were significant in advancing racial prejudice. “European culture” was introduced to the "natives" who were regarded as incapable of taking care of themselves. With the National Party, which had

come into supremacy in 1948, all its dogmas were based on “racial discrimination”, which further accentuated the exclusion of blacks from the social political and economic realm of the white minority. In 1948 the policy of apartheid was embedded in legislation. Access to justice was racially defined and the perception was created that the CJS was indifferent to the welfare of the “black” people (Dissel & Kollapen, 2002:15).

South Africa became a republic in 1961 and in 1982 a tri-cameral parliament started operating wherein the white minority still dominated legislation. Mokoena (2007:26) maintains that criminality and political affairs in South Africa have been interwoven and if one went against the “apartheid” doctrine you were committing a crime. He further suggests that conquest, colonialism, and apartheid were innately violent systems that bred criminality and violence among people and the law makers.

Presiding Officers at all court levels under apartheid were civil servants who were not taken from the legal fraternity but from the public service. They were accountable to the state and therefore, in effect, this compromised their independence. Furthermore, magistrates and judges were predominantly white males who supported the National Party government during this era.

Independent Black States had their own CJS and in 1994, South Africa had its first democratic election and with it a change in the political landscape and an end to apartheid (Abrahams, 2001). The Government is now a constitutional democracy and laws are subject to the Constitution, Act 108 of 1996. Regardless of the paradigm shift, race remains a foremost element in the operations of the CJS (Dissel & Kollapen, 2002:19). South Africa has a mixed legal system of Roman Dutch rule, English common rule, and customary regulation (Central Intelligence Agency, [sa]).

Policing in South Africa went through various phases, from the era of 1652 – 1884, which saw the appointment of officials by Jan van Riebeeck to defend settler land, control interface with the number of Blacks with whom they shared territory as well as to control stock theft (Vuma, 2011:17). In 1910, the provincial,

municipal, and rural police forces were recognised and expressed in different and separate proclamations or acts. The police force was reorganised into two separate forces in the late 1911s, namely the South African Police and the South African Mounted Riflemen, all of which were tasked mainly with conflict management in the country (Vuma, 2011:23). This, however, lasted for approximately nine years and culminated in the combination of the two into a single police force in 1920.

The South African Police Force were very visible during the apartheid years when the CJS and the police were used to impose innumerable prejudiced and discriminatory laws, as well as to uphold the apartheid dogma of excluding non - whites from participating in the economy of South Africa (Vuma, 2011:23). The South African Police Force was changed in 1995 to the South African Police Service (SAPS) in line with the South African Police Service Act, Act 68 of 1995 and a shift towards the prevention of crime, and community policing (Mokoena, 2007:91). Suffice to say, corruption is rampant in the SAPS (Rajin, 2017:2).

South Africa's justice division consists of its highest courts, namely, the Supreme Court of Appeals, (made up of the court president as well as a deputy president and 21 judges); the Constitutional Court, which consists of the chief and deputy chief justices and nine judges; and the subordinate courts, which include the High Courts, the Magistrates' Courts, the labour courts, and land claims courts (Central Intelligence Agency, [sa]). The CJS is administered nationally. It is an adversarial system where the state prosecutor presents cases against the accused. In terms of the Constitution, the judicial authority of South Africa is entrusted in the courts and the judiciary is conditional upon the Constitution and is therefore independent.

The South African criminal justice system has increasingly acceded to the call of the public to be tough on criminality. The continued lack of staff in the police service, the increasing case backlogs, overcrowding in detention facilities, and the poor conditions of correctional facilities, have had many people describing the CSJ as inefficient and weak (Masiangoako, 2017:1-2). Discussions on changing and improving the criminal justice processes emanated from the National Crime Prevention Strategy (Department of Safety and Security, 1996:7) to include the

Department of Correctional Services' role in, amongst others, the rationalisation of legislation (Plaatjies: 2005:41). The CJS was reviewed (initiated by the Cabinet in 2007) in an effort to transform the CJS from a disjointed system that has no focus into a fully competent and focused system that will not work in isolation but integrates its services with other role-players in the Justice Crime Prevention and Security Cluster (JCPS) so that value for money is obtained. The departments that constitute the JCPS are the Department of Justice and Constitutional Development (DoJ&CD), the South African Police Service (SAPS), the Department of Home Affairs (DoHA), the National Prosecuting Authority (NPA), the Department of Correctional Services (DCS), and Legal Aid South Africa (Legal Aid SA) (National Planning Commission, 2011:351). This is in fulfilment of the JCPS Delivery Agreement (Department of Justice and Constitutional Development, 2017:22).

The South African legal system is not designed to have every case reach trial, thus the provision of a criminal justice system that aims to divert children's cases before they reach the courts and places children in the care of parents or guardians in appropriate cases.

The varying application of the law to people in South Africa in a post-democratic South Africa, has failed to uphold what one of the most enlightened constitutions of the world promises (Oechsli & Walker, 2015). Recent events such as the Marikana incident has not yet been finalised and the families of the victims are still waiting for justice to be served (Mitchley, 2020), have led people from all over the world to question the criminal justice system in South Africa, contributing to the diminishing credence of the law and the CJS. The Esidimeni tragedy is also another example of this. Masiangoako (2017:1-2) states that this is based on multiple factors such as your status in life, your "connectedness" to those in powerful positions, where you are from, how much money you have and what your socio-economic background is. The case of The State v Dewani reeks of how the immense financial wealth of a defendant may significantly affect the outcome of their case (Ngobeni, 2014; Rajin, 2017:15).

2.4.2 History and Theory of Correctional Systems in South Africa

The approach that is to be used to illustrate the history and theory of correctional systems is to discuss developments in periods of significance, as well as to look at a chronological approach which focuses on dominant events or changes in legislation that are brought about by political, cultural, social, or economic events (Vormbaum & Bohlander, 2014:3).

South Africa was subjected to Dutch invasion in 1652 and British colonialism from 1806. In 1910, South Africa was Unionised and thereby ruled by both the English and Afrikaners as the Union of South Africa (Central Intelligence Agency, [sa]). South Africa was divided into four colonies, each with their own approaches to dealing with those who were in conflict with the rule of law. Dutch colonists introduced "prisoners" to South Africa, but it was subsequent to the British occupying South Africa that the penal law, including detention, began to be formalised (Singh, 2005:38).

During the time of the Dutch invasion (pre-1900s), criminals were punished through public executions and public crucifixions (Oswald, 2007:2). They were occasionally chained and held in the Dutch East India slave lodges (Singh, 2005:17). Criminals had to do manual labour and work in public works, yet in order for the Dutch to fulfil its aim, many detainees were sent to Robben Island in order to keep detainees away from society (Oswald, 2007:2).

The first South African prison was built in 1781 and another 22 in the following 50 years (Plaatjies, 2005:27). Physical harm as punishment to criminals began to decline after the British occupied the Cape in 1795. In 1803, punishment that resulted in corporal suffering was abolished (Singh, 2005:18). Following this, was the abolishment of the slave trade in 1834, and this meant a decline in the supply of labour to farms. It was at this time that the pass laws were also introduced (Oswald, 2007:2).

During the 1840s and 1850s, the hard labour rule continued and detainees were involved in public work such as the building of roads and ships (Dissel & Ellis,

2002). They had to enter into contracts of a maximum of five years with or without remuneration (Singh, 2005:20). The State continued to provide menial black labour. In 1885 detainees were for the first time, employed to work in mines (Oswald, 2007:3).

The detention facilities were congested, and unhygienic, and physical punishment was common (Singh, 2005:19). In 1888, "Act 23 of 1888 to consolidate and amend the Law relating to Convict Stations and Prisons," (Act 23 of 1888), was passed by the Cape Parliament. This Act brought about a single detention system and did away with the varied places of detention. This Act, together with the tripartite classification system, introduced the classification of detainees according to their gender as well as the separation of the various categories of detainees (Singh, 2005:19).

The early 1900s saw the pronouncement of the Criminal Law Amendment Act 38 of 1909, which made hard labour a sentence for those categorised as habitual criminals and the courts started to play an inordinate part in creating prison law (Oswald, 2007:4; Singh, 2005:27). The Prisons and Reformatories Act 13 of 1911 repealed all penal system legislation effected before the Union of South Africa, and continued with detention of road camps for petty offences committed, and introduced the establishment of reformatories for juveniles (Republic of South Africa, 1911a: 12-62; Singh, 2005:21).

Section 14 (e) of the Prisons and Reformatories Act 13 of 1911 makes specific reference to the admission of "lunatics". No controller, assistant controller, or "gaoler" in charge was allowed to admit or receive a "lunatic" unless there was a specific order authorising the detention of the lunatic at such an institution. The Act further states that the facility shall not receive such an alleged lunatic if there is a lunatic asylum or public hospital in the vicinity unless that public hospital is used exclusively for the control of an infectious disease. Furthermore, these alleged "lunatics" were permitted to receive food, bedding, and clothing from family or friends from the outside. They were also not forced to wear clothing issued by the authorities and neither were they compelled to perform work unless it was prescribed by the medical officer (Republic of South Africa, 1911a: 14-17).

Further to this, any insane detainee or convict that was removed from the detention facility to a “lunatic asylum” ought be returned to the detention facility to complete his/her sentence and it was permitted that this period be regarded as part of his sentence served (Republic of South Africa, 1911a:30).

Courts, in the early 80’s, brought about a system of remission or early release (Department of Correctional Services, 2005:47; Singh, 2005:26). Remission refers to the organised system that aims to persuade detainees towards self-development and improved behaviour which contributed to the detainee’s early release (Justice Action, 2012:3).

Rampant in South African detention facilities, were human rights injustices such as racial seclusion, harsh punishments, solitary confinement, whipping/lashing, dietary punishment, and additional labour, and the death penalty directed mainly towards the “poor and the powerless” (Department of Correctional Services, 2005:46; Singh, 2005:21).

Although there was a disregard for the detainees human rights, the courts brought about changes for detainees who felt that they were falling short of being treated fairly (Oswald, 2007:4). A major change saw Prison Services being in control of reformatories which accommodated juveniles as well as what was termed inebriate reformatories (Republic of South Africa, 1911a:46). The Prisons and Reformatories Act 13 of 1911 introduced a system of early release, and also changed the approach to the management of awaiting trial detainees. Awaiting trial detainees were not to be kept in isolation and detainees who thought that they were treated unfairly had a legal right to approach the court for intervention (Plaatjies, 2005:27). Many thought that this new piece of legislation would turnaround the harsh environment towards a reformative rehabilitative agenda across the racial divide of the detainee population, but this was not so.

Regulations developed in 1911, specifically article 102, make provision for the medical officer to approach the Director of Prisons for any special or additional advice if he/she suspects that the mental age of any convict is being debilitated by continued detention (Republic of South Africa, 1911b:118). It also provides for the

medical officer to examine the “lunatic” before he/she is sent to a “lunatic asylum” and record and report any injuries. Article 45(2) of the said Act places an obligation on the superintendents to inform the medical officer of a “mentally diseased” person. Detainees with a “mental disease” were separated from other detainees. It was also the responsibility of the superintendent to report to the “director of prisoners” of any detainee suffering from serious mental illness (Republic of South Africa, 1911b:104-106).

A restructuring in the penal system occurred during the taking over of the Orange Free State and the Transvaal by the British in the mid 1900 (Singh, 2005:20). The detention facility structure was military style in the 1950s, when officers were adorned with military regalia and titles. Detention facilities were established for the purpose of providing labour for the purposes of the development of the country, in building roads and harbours (Dissel & Ellis, 2002). Suffice to say, convicts continued being used by mining companies as cheap labour, and so the cycle of providing labour to companies for the so-called betterment of the economy of the country remained. Prison Services were managed by, and reported to, the Department of Justice (DOJ) (Department of Correctional Services, 2005:46).

A Penal and Prison Reform Commission (also called the Landsdowne Commission) was established in 1945 by the Penal Reform Committee of the South African Institute for Race Relations for deterring progress against the Prisons and Reformatories Act 13 of 1911. Amongst its recommendations was that detainees should not be rented out for low-priced labour, and that literacy programmes must be extended to Blacks (Department of Correctional Services, 2005:47; Singh, 2005:23). This led to the Criminal Procedure Act 56 of 1955 adding Section 352(1) concerning alternatives to imprisonment, such as community sentencing.

With the new political regime in 1948, the doctrine of apartheid was made law in South Africa, under the Nationalist Government. With this came the introduction of the Prisons Act 8 of 1959 which did away with the terms ‘lunatics’ and ‘asylum’

and introduced the terms ‘mental cases’ and ‘mental hospitals’ (Republic of South Africa, 1959).

The Prisons Act 8 of 1959, in particular, Section 20(1)(c) gave authority to the Minister of Justice to establish detention facilities to serve as observation centres for determining, amongst others, the mental condition of “prisoners”, their age, health, character traits, social background, previous conduct, ability to work, aptitude, and training of selected detainees with a view to their classification and separate accommodation (Republic of South Africa, 1959:14). Further to this, mention is made in Section 27(2)(1) that no “mentally defective” person may be incarcerated unless there was an order for commitment. A mentally defective person shall not be admitted if there was a mental hospital or a public hospital in the district in which such a prison was situated. Further sections of the Act [Section 34(l)] authorise the removal of a convicted detainee to a mental hospital and who must be returned to the prison as soon as s/he is fit for to complete his/her sentence (Republic of South Africa, 1959:22). Authorisation that the period during which such prisoner was detained in a mental hospital, be counted as part of his/her sentence of imprisonment lay with the Minister of Justice (Republic of South Africa, 1959:22).

In as much as South Africa acknowledged International frameworks that guided the management of detainees such as the then-called United Nations Standard Minimum Rules, there was no progression towards this, and human rights of detainees still remained violated (Department of Correctional Services, 2005:49; Dissel & Kollapen, 2002:35; Oswald, 2007:4;). Detainees were classified into ultra-maximum, maximum, and medium, and detention facilities were categorised as open prisons and as observation centres in 1959. During this time, a parole system was introduced (Singh, 2005:23).

The management of detention facilities under the legislation of the Prisons Act 8 of 1959 was grounded on the dogma of apartheid. The administration of detainees was embedded in the military approach and “white” warders were regarded as being superior to “black warders”. Apartheid corrupted the CJS as well. Black people were fundamentally barred from positions of power in the judicial system,

in the police and in prison services (Dissel & Kollapen, 2002:79-80). Detainees became non-transparent to the outside world since Article 44 (1)(f) of the Prisons Act 8 of 1959 disapproved of any publications of life in detention or conditions of detention (Oswald, 2007:5).

During this regime, there was an increased detention of political detainees and more so with the State of Emergency which was declared from 21 July 1985 till 1990. Many people were incarcerated without trial. Political detainees at Robben Island were compelled to do physically hard labour, which was combined with severe punishment and beatings under conditions which can be referred to as barbaric (Oswald, 2007:8). A political detainee, Indres Naidoo, having been exposed to the extreme violence meted out to such detainees was imprisoned on Robben Island from 1963 to 1973. He speaks candidly of the political detainees being assaulted with *rubber hoses, batons, or anything that the warders could lay their hands on* (Dissel & Kollapen, 2002:31).

Political detainees took the opportunity to challenge authorities and defy conditions under which they were subjected. In as much as these facilities became closed institutions, word still went out to the International world of the gross violations inherent in South African detention facilities and with it an increased external pressure to adhere to International Guidelines (Department of Correctional Services, 2005:49; Dissel & Kollapen, 2002:31). The majority of South African people as well as the international community started questioning the legitimacy of the CJS in South Africa (Cilliers, [sa]:533).

Amendments to the Act 8 of 1959 by the Prisons Amendment Act 75 of 1965 brought with it a new hope for better living conditions for incarcerated persons and a redirected emphasis towards rehabilitation of detainees in line with a modern penological direction (Louw, 2008:25; Singh, 2005:23-25).

Mass arrests took place between 1975 and 1984. The majority of those arrested were Blacks who were arrested for various forms of opposition to apartheid. Trivial though these infractions may have been, they were not spared. Approximately 1.9 million people were arrested, mainly for the non-adherence to

the ruling that required particular race groups to have their identity documents, known as 'passes' on them at all times. Other reasons for imprisonment were the violation of the Immorality Act which disallowed inter-racial marriages in South Africa (Dissel & Ellis, 2002; Oswald, 2007:5; Plaatjies, 2005:28). These numbers also included youth who were detained for protesting against Bantu Education in 1976 -1977 and in 1980 (Singh, 2002:27). This led to the detainees being filled with detainees awaiting trail who were detained for their opposition to the régime (Dissel & Ellis, 2002). The conditions since the inception of detention facilities had been described as appalling (Plaatjies, 2005:21).

In 1988, racial segregation was relaxed, and in 1990, significant changes were brought to the fore. These changes included demilitarisation, a focus on detainee's health, and inspections to be conducted in detention facilities by independent bodies (Oswald, 2007:6). The system of apartheid was formally done away with in the 1990s and the Prisons Act 8 of 1959 was further amended as the Prisons Amendment Act 92 of 1990 (Singh, 2005:29). The amended Act gave authority to the Minister of Justice to establish "hospital prisons" for psychopaths as certified in terms of the Mental Health Act 18 of 1973; or those apparently suffering from psychopathic disorders and who had been referred for observation (Republic of South Africa, 1990:8). Despondently, many of its mechanisms of authority and control persisted in the new dispensation (Dissel & Ellis, 2002). The amendments also prohibited strikes by the warders.

Prison Services was given a new name - the Department of Correctional Services in 1991, and was detached from the Department of Justice (Cilliers, [sa]:534); Department of Correctional Services, 2005:50). With this came the concept of non-custodial sanctions, yet transformation in this regard still posed a challenge (Cilliers, [sa]:534; Plaatjies 2005:29). The Prisons Act 8 of 1959 was further amended in 1991 through the amended Correctional Services and Supervision Matters Amendment Act 122 of 1991. This brought with it the requirement of the submission of reports on a prescribed form by officials. The form prescribed recorded inputs with regard to the behaviour, adaptation, development, aptitude, work opportunities within the detention facility, the physical and emotional adjustment (mental), as well as the possibility of relapse into crime, of every

detainee who is detained in the facility (Republic of South Africa, 1991:15-16). The Criminal Procedure Act 51 of 1977 was also amended in 1991 for the implementation of correctional supervision (Singh, 2005:27).

A landmark case in 1993, namely, Minister of Justice v Hofmeyer, ruled that a "prisoner retained all his personal rights" besides those that are necessary for the maintenance of good order (Oswald, 2007:6; Dissel & Ellis, 2002; Maseko, 2014:4-5). This, together with the Medical Act No 68 of 1993, stipulated that no person suspected of being mentally ill or whose mental illness was being investigated could be brought before a disciplinary committee unless a certificate was issued confirming the mental competency of the accused (Republic of South Africa, 1993b:15-16).

2.5 GERMANY

European supremacy struggles engrossed Germany in two detrimental world wars in the early 20th century. Two German states were formed in 1949 during the Cold War, namely the Western Federal Republic of Germany (FRG) and the Eastern German Democratic Republic (GDR). The end of the Cold War, together with the weakening of the Union of Soviet Socialist Republics (USSR), resulted in German reunification in 1990 (Walmsley, 2018a).

2.5.1 Criminal Justice System in the Federal Republic of Germany

The Federal Republic of Germany is the largest country in Europe, and it consists of 16 states (also called Leanders). Its capital city is Berlin (since 3 October, 1990), and its population stands at approximately 80 457 737 as at July 2018 (Walmsley, 2018a).

Germany, being a constitutional democracy, with a government type being that of a federal parliamentary republic, has a legal system which takes the form of a traditional civil law system (Lehmann, 2018; Reineke, 2009:118). The Federal Republic of Germany has a Federal Constitution known as the Basic Law

(Grundgesetz) and this takes priority over state laws (Federal Republic of Germany, 2012: 8-14).

Crime and criminal justice were initially approached from a social perspective in Germany. Not much has been documented on crime and criminology in Germany pre-1980s, however, two historians, Küther and Blasius, attempted to explain patterns of crime and criminal justice history pre-1980s. Küther explained that banditry was a primeval and ancient form of political and social defiance by the "vagrant lower class" against the ruling elite, much to the dissatisfaction of his critics who said that these were entrepreneurial acts which followed the norms of conventional social order (Reineke, 2009:118). Blasius explored bourgeois society and criminality in 19th century Prussia during amendments in agricultural land ownership, which he believed led to the destitution of the poor in the countryside (Reineke, 2009:119).

The late 1980s emphasised the "cultural meanings" of crime, sexual offences, youth crime, penal policy and processes, and the utilisation of the courts for resolving conflicts. This period saw penal institutions not only as a means for the application of punitive endorsements, but also as a "*dispositive"* within societal disputes (Reineke, 2009:119).

In the period 1815 to that of the Second Reich in 1870-1871, the police were seen as constituting an extralegal institution and their powers went beyond that of policing tasks. The "police of the *Kaiserreich* (1870/1871-1918)" placed emphasis on the relationship between the military, the wealthy nobles, the state bureaucracy, and the industrial entrepreneurs. In addition to the control of criminality, the police also focused on the governing of the working class in the clampdown on unions and political organisations (Reineke, 2009:119).

Changes in the police were brought about after 1945. These changes included the elimination of the Gestapo, the removal of Nazis among the police, the full obliteration of the traditional German police system. This led to the implementation of the "English model" where the state police were replaced by the local and communal police forces (Reineke, 2009:129).

The German high courts consist of the Federal Court of Justice. It is structured into 25 senates which are further subdivided into 12 civil panels, five criminal panels, and eight special panels". The Federal Constitutional Court (Bundesverfassungsgericht) consists of two senates in each court and is each further divided into "3 chambers, each with a chairman and 8 members" (Central Intelligence Agency, [sa]).

A constitutional court is found in each of the 16 German states. The subordinate courts also include the Federal Administrative Court; Federal Finance Court; Federal Labor and Social Court; civil, criminal, family courts, and specialised (administrative, finance, labour, social) courts (Central Intelligence Agency, [sa]).

The courts use an inquisitorial system in criminal matters as opposed to that of South Africa and Nigeria. If a crime has been committed, then the police or the district attorney must start an authorised investigation. If the matter emanates to a trial, the court is obliged to firstly, carry on with further official investigations, and secondly, to look for evidence (Lehmann, 2018).

After the police administer a case, the case is handed on to the Public Prosecution. In the event that the case can be dealt with quickly and does not involve a juvenile, then an "accelerated proceeding" is applied for where a formal charge is not filed. In the case of a juvenile detainee, the Public Prosecution Office applies for a "simplified proceeding" (Jehle, 2005:8). There are different juvenile courts for criminal cases against juveniles and young adult detainees.

Courts are hierarchically composed, and the number of judges chosen to preside over a case is done according to the length of possible sentencing. For example, if the sanction/sentence is probably going to be two years' detention and less, the case is heard by one judge. In the event that the presumable detainment is somewhere in the range of two and four years, at that point the case will be heard by a judge and two lay assistants (Jehle, 2005:26).

In all instances, where confinement to a psychiatric hospital or to preventive detention (post-imprisonment) is to be the likely outcome, cases will be presided

over by the Small Criminal Chamber at a regional court (Jehle, 2005:8). Juvenile courts are also hierarchically organised.

The German prison system is centralised around the principles of resocialisation and rehabilitation – much in the same way as that of South Africa and Nigeria. In the United States (US), incapacitation and retribution are primary reasons for incarceration, and rehabilitation is secondary, even though policy may indicate otherwise. Further to this the principle of “normalization” applies, where detainees are afforded similar, if not the same, services in detention facilities to that of the community (Subramanian & Shames, 2013:7).

2.5.2 History and Theory of Correctional Systems in Germany

It is difficult to get information and proper chronology/sequence of the German prison system operating in the 1800s. This understanding is important to determine transformation in the field of punishment. The 1800s was rife in meting out brutal corporal punishments in detention centres (Arnold, 1995:81). Asylums, detention facilities and similar establishments for people who contravene the rule of law existed early in Germany’s history. According to Reineke (2009:122), detention was common before the 1800s and corporal punishment lasted well into the twentieth century. It must be borne in mind that the history of Germany must be understood, in order to gain an understanding of both the political and social history which shaped the history of German detainees. This would mean discussing these changes according to Imperial Germany (1871–1918), the Weimar Republic (1919–1933), and the Nazi regime (1933–1945), and then the co-existence of two political systems from 1949. Accounts of the death penalty in German detainees during the Nazi period indicate further the degree to which brutal and inhumane approaches to detention persisted. These approaches aimed at getting rid of detainees rather than ameliorating their development through rehabilitation efforts.

The "Prussian General Law" of 1794 saw a “two-track" system of punishments for detainees (Salize et al., 2007:152; Hartmann, 1911:349). This system meant the application of, firstly, temporally *partial detention* sentences being imposed on

detainees who were conscious of their actions and consequences of their action. Secondly, it meant temporally *indefinite detention* for detainees who were not conscious of their responsibility and who still posed a danger to society. This system opens up the option of offender-focussed treatment and development instead of resorting to an offence-directed punishment, whilst simultaneously protecting society from further crimes (Eser, 1973: 250; Salize et al., 2007:9). During the 18th century (Imperial Germany), mentally ill detainees were often detained in asylums or workhouses together with the non-criminal mentally ill (Salize et al., 2007:6). Early debates ensued around the idea that mentally ill detainees should not be convicted because of a "lack of criminal responsibility". In early times, it was an accepted practice to exonerate/release mentally ill persons who violated the law instead of detaining them in mental hospitals. This led to high reoffending rates of mentally ill detainees (Salize et al., 2007:6).

The two-track system was incorporated into German criminal law with the passing of the "Act against Dangerous Habitual Offenders" in 1933 which, before being misrepresented under National Socialism, endorsed for the first time that mentally ill detainees be committed to psychiatric institutions as a compulsory measure (Salize et al., 2007:9). In what is termed "hospital orders for the mentally ill" orders were made for an indeterminate period. The concept of "indefinite time" sustained the idea that it is the responsibility of the detainee to reclaim his freedom by reforming his behaviour and character (Hartmann, 1911:351). Goldberg (2002:1) clearly describes the abuses that such detainees suffered even if they infracted on minor offences. These abuses included being shackled to toilets, being kicked, being stripped naked and left in isolation cells, being "douched" and not being allowed visitors nor being allowed letters from the outside. This has since then changed with the belief that it is cheaper and better for the public to improve a criminal than to break him down (Hartmann, 1911:351).

As a part of the increase in the number of mental hospitals for such purposes during the 19th century, some places offered dedicated facilities for mentally ill or disordered detainees (Salize et al., 2007:9).

The detainees, prior to Hitler's taking over, were managed by a group of civil servants who adhered to the rule of law according to regulations. The German detention facilities accepted only those Germans sentenced by the ordinary German courts. Robbers, sex offenders, and a few German political detainees went to the civilian detention facilities where they were detained under a severe and laborious regime.

Detention during the Nazi period must be chronologically unfolded, in order for one to gain documented insight into the management of the concentration camps.

Table 1: Germany's detention timeline under the Nazi Rule

Date	Event	No of detainees
October 1934	Mass arrests of left-wing opponents in 1933	2 400
Summer 1935	Early camps start spreading across Germany SS takes over the remaining camps in 1934	3 800
Nov 1936	New camps for men are established	4 761
March 1937 -	Buchewald camp starts operating	2 000 Ex – convicts
December 1937	Reich Decree for preventative custody of criminals and asocials	7 746
June 1938	First official execution takes place	24 000
November 1938	26 000 –Jewish men sent to camps	50 000
August 1939	Women's camps open – such as Ravensbruk Mass detention of Poles in camps	21 000
December 1940	Auschwitz starts operating	53 000
December 1941	Euthanasia – murder of weak and ill detainees	80 000
September 1942	Mass deportation of Jews to Auschwitz	100 000
August 1943	Mass deportation of Gypsies to Auschwitz Dora underground camps starts operating 18 000 Jews murdered in Majdanek	224 000
August 1944	Mass deportation of Jews from deep within Germany to concentration camps. Uprising in Auschwitz	524 286

Date	Event	No of detainees
March 1945	Over 18 000 detainees die in Bergen-Belson	Over 700 000
April 1945	Camp evacuations An estimated 300,000 detainees died. Liberation of Dachau.	550 000

Source: Wachsmann (2015)

Adolf Hitler and his Nazi Party governed Germany between 1933 to 1945. His dictatorship converted the country into an autocratic totalitarian state that controlled virtually all aspects of the country and its inhabitant's lives. He had no belief in the German penal system.

When Hitler realised that civil servants did not fully co-operate in running detention facilities according to the Gestapo's measures, he established the concentration camps. These camps were a thorough "emasculation" of the independence of the German judicial system (Bennett, 1946:371). The old penal system of describing distinct crimes, transgressions, and criminals was completely obliterated. And so, the entire construction of the Roman law, the Justinian and Mosaic codes and classical legal guides/precedents which formed the foundation of German law were ignored (Bennett, 1946:373).

Detainees during this time, were housed in camps which consisted of political opponents of the Nazi state or those that were "racially inferior". The concentration camps that they were kept in expanded and quickly included imprisonment that was aimed toward forced/coerced manual labour and, as explained by the Vera Institute of Justice, the concept of "extermination through work" (Frank, 2018). Among such camps were Neuengamme, Dachau and Auschwitz. Here, detainees were stripped of all human self-esteem and dignity. After World War II, Neuengamme was converted into a detention facility and from 1950 to 2004, two such facilities operated at Neuengamme. Nazi dictatorship was steeped in racial extremism and the commitment of horrendous crimes against people and by people. Almost 60 million were massacred in the war and in the extermination camps which were at central to the many camps started by the

Nazis. There were camps to discipline, punish, exploit, and murder, and assisted to entrench Nazi rule, who increasingly led the inhumane physical attack on outsiders and adversaries, and engaged in the murderous war against Jews and detainee populations. At least around 400,000 were from the concentration camp system (Deutschland.de paper, 2012).

Some of the detention facilities were more modem under the Nazi regime, but there was very little done to rehabilitate the detainees. There were very few educational and training amenities, no parole system, no credit system for good conduct, and no consideration for the specific needs of the detainee (Bennett, 1946:373). This was done as a way to get detainees into the army to perform especially dangerous duties such as working in the bomb clearance squads (Bennett, 1946:374). During this time, old theories of Lombroso on criminal characteristics both physical and mental were tested out on detainees and therefore experimented on, many of which led to deaths (Bennett, 1946:374).

Wachsmann (2015) states that the history of camps started in 1933 where 25 concentration camps and over 1 100 attached satellite camps existed during Nazi rule. These camps gradually increased in numbers since their becoming operational but what must be known is that not all of the camps existed at the same time, as can be seen in the above Table 1. The detainee population numbers changed periodically due to influences from events in Germany's timeline. During this time, there was no particular model for these camps and conditions of detention also changed frequently.

Many were mistreated and met with hostile violent conditions, and capital punishment was clearly dominant during this period (Dessecker, 2009). Adolf Hitler believed in the benefits of unlegislated terror, without courts and judges (Wachsmann, 2015).

Auschwitz, which was established in 1940 to obliterate Polish resistance, was the first of numerous new camps. Detainees were met with constantly putrid conditions which were worsened by disease, contamination, and hunger. Many more were exterminated or killed as a result of horrifying and atrocious "medical

experiments". From 1942 to 1945, six million European Jews were massacred by the Nazis through gassing or shooting (Wachsmann, 2015).

Detainee numbers grew fast during the second half of the war, and by early 1945, there were over 700,000 persons in detention. Approximately 2.3 million men, women, and children were detained in concentration camps between 1933 and 1945. Categories included criminals, Jews, homosexuals, political detainees, Gypsies, Soviet "prisoners" of war and Jehovah's Witnesses. The "Shutzstaffel" (SS) or "Protective Echelon", ruled the concentration camps with an iron fist. It enforced inhumane rules and unbending schedules. Detainees were also held in satellite camps which were found close to factories and building locations. They were utilised as slave workers and worked long hours in hard labour which included, amongst others, building streets, digging burrows, and breaking rocks (Wachsmann (2015).

The present German Reich Penal Code took effect in 1871, and according to Eser (1973:246) was "already antiquated at birth" in the sense that it did not bring about any significant transformation with regard to detention management. There was a call for the urgent reviewal of the document 30 years later at the 26th Meeting of the German Bar Association in 1902 (Eser, 1973:246). Subsequently, seven volumes of Material for Criminal Law Reform were drafted, and this led to the many drafts of the "Criminal Code" being produced (1927, 1936, 1954). It was slow to be finalised but was eventually submitted in 1962. Even then, it was said to lack transformation in penal policy. However, improvements were made in 1920 with the Penalty Extinction Law of 1920, which allowed for the swift annulment of prior convictions, which in a way assisted with the rehabilitation of detainees (Eser, 1973:247). In 1923, the first juvenile delinquency law in Germany was established, namely Juvenile Court Act of 1923, which elevated the criminal capacity of children/juveniles to 14 years from the previous 12 years. It also modified the approach of trial proceedings against children, those specifically between the ages of 14-18, from criminal to social protection (Cantor, 1934:84) and for the first time, added a developmental approach to detention (Eser, 1973:249). While the German Republic was living through the struggle of a new-born country, torn socially, politically, and economically, and experiencing a

revolution, reforms in the penal code finally took off (Cantor, 1934:84). On August 1, 1923, Prussia, the biggest German State, dispensed its "Dienst-und-Vollzugs-Ordnung", which was a set of guidelines governing detention administration. Many states then issued similar rules (Cantor, 1934:85). Of considerably more noteworthy significance than this reform of the Penal Code, were the endeavours to unify the standards and principles of penal administration in every state in Germany.

It ought to be noticed that each of the states or "leanders" of Germany has exclusive jurisdiction over its detention facilities and monitors its autonomy in punitive issues. No national/federal law administers prison administration, despite the fact that there is just a single Federal Penal Code administering the whole nation. This has created confusion, particularly in those states that were least open to reform (Cantor, 1934:85).

Changes to detention administration came in the form of an "Order of June 7, 1929, The Grade System in Prison Administration in Prussia" issued by the Prussian Ministry of Justice. This Order was an advanced expansion of the earlier 1923 regulations. The aim thereof, was to teach the detainee how to live a law-abiding and disciplined life, which was thought to be possible through the separation of the different categories of detainees. This meant that those with severe mental deviation were to be separated from the general detainee population. Those detainees with less than nine months' sentence were separated from those with longer sentences, and confirmed reoffenders who were uncertain to rehabilitate were also separated from those that had potential to rehabilitate (Cantor, 1934:85 – 86).

Prussia structured its prison system accordingly into "entrance prison"; "prison for advanced prisoners"; and "discharge prison". The entrance prison was further separated into various other types, usually four or five types: an "institution for minors" and those with petty previous convictions; an institution for detainees serving short sentences; an institution for returning adults; an institution for first offenders; one for the "least reformable"; and one for those who were seriously mentally ill (von Hentig & Willen, 1931:177–178). The privilege system made

provision for detainees to earn credits for good behaviour, and as a result of this good behaviour, were able to progress from being Grade 1 offenders from the "Admission/entrance institution" to the "Institution for the Advanced". Those that reached the "Discharge institution" were those that behaved themselves in an exemplary manner (Cantor, 1934:86). The numerous prison regions into which Prussia was divided, did not adhere to the "new" Order. By 1939, there was only one overcrowded detention facility for the mentally ill in Berlin. This facility had a detainee population of 500, 40% of whom were previously detained in an institution for the mentally ill (Cantor, 1934:88).

In 1939, 4000 convicted persons were detained in mental health institutions and 340,000 inpatients that were "non-criminal commitments" and according to Dessecker (2009) from 1939, mental patients were systematically murdered.

During the Nazi regime, Hitler changed the prison administration by effecting even more severe measure. They instated neutering and castration procedures extensively. Detainees were kept in solitary confinement for long periods of time, the derainees were forced to work 14 to 16 hours a day with no opportunity to gather with other detainees, with no group sports, nor even to eat together as a group (Bennett, 1946:373).

Germany practiced preventative custody, which allowed the state powers to detain people without a hearing. It applied to those detainees who had been indicted of three crimes in the past. The goal of preventative custody was to "prevent future crimes." If the warden believed that an individual subject to preventive detention may still be perilous, all he needed to do was to inform the court and the detainee could be held in custody for an indefinite time. Germany also practised a system of protective custody which was a legal method allowing the Gestapo to imprison or even to "execute" an individual who was thought to be a danger to the public or to compromise the resolve of the Fuehrer (Bennett, 1946:375).

The imprisoned people were not supplied sufficient food or water, and in some cases were not given any water or food. These detainees had to work in

“extreme” unhygienic, unhealthy, and dangerous conditions (Frank, 2018). Germany’s annexation of Poland in 1939 led to World War II (WWII).

In May 1945, Nazi Germany surrendered totally. After WWII, Germany was divided into four zones depending on military tenure (United States, the United Kingdom, the Soviet Union, and France). Socialism was fostered in the east by the Soviet Union, whilst the west of Germany propagated a parliamentary democracy, resulting in the Cold War. Two constitutions were approved for Germany, a constitution for the Federal Republic of Germany, approved by the Allies, and the other communist influenced constitution was approved for East Germany. The German Democratic Republic (GDR) was established in the “eastern zone” on 7 October 1949, and the final lot of German prisoners of war returned to the GDR from West Germany in 1956 (Deutschland.de paper, 2012). The GDR abolished preventative detention.

The 1960s were characterised by demonstrations of students and academics against “incrusted structures” and stringent standards, and these brought about a permanent transformation in the political philosophy and society of West Germany. Issues on women's liberation, authoritarian education, sexual freedom, rebellion, and new freedom were debated vigorously (Deutschland.de paper, 2012).

There were five kinds of confinement in Germany before 1970, namely, the Zuchthaus (prison), Gefängnis (prison), Einschließung (jail), Arbeitshaus (work-house), and the Haft (custody). A Zuchthaus which was a detention facility of tough, physically strenuous labour, which often led to fatalities, was abolished by a reform of the penal code, which was effected on March 31, 1970.

The external world considered the 1970s is a period of peace, but within Germany there was rife in-house tension. The Red Army Faction (RAF) threatened to disrupt the government, the economy, and society (Deutschland.de paper, 2012). In 1973, the Federal Republic and the GDR came to an agreement in the Basic Treaty to institute usual “neighbourly associations” with one another (Deutschland.de paper, 2012).

Germany's penal reform brought about changes in the accommodation of the mentally ill in 1975 and will be discussed in the next chapter.

2.6 NIGERIA

2.6.1 The Nigerian Criminal Justice System

History of the CJS in Nigeria dates back to the pre-colonial era where customary law was proficient and customary traditions were used to hand out punishments to detainees. The king's guards were appropriated the role of modern-day police since there was only the community police, and no central police system. Judges were obtained from the King's councilmen. There were detention facilities in most Nigerian cultures which were used for detainees awaiting trial and whose cases were not yet finalised (Adeosun, 2018).

The Nigerian CJS is a combination of laws founded in common law principles, customary law (Islamic law - in 12 northern states), traditional law, and British parliamentary law enacted prior to October 1, 1960 (United Nations Office on Drugs and Crime, 2004).

Three main agencies in the Nigerian criminal justice system are the police, the courts, and corrections (Olonisakin et al., 2017:33). The Nigerian Criminal Justice System is established on three legislative frameworks. Prior to 1999, the Criminal Code, that governed the states in the South, and the Penal Code, that governed the states in the North, existed for legislating the activities of the criminal justice system. This is still applicable and forms the basis of current criminal reform. Since 1999, the Sharia Penal Code was introduced and is applicable to Muslims (Nwamaka, 2011:145). These codes co-exist but the three structures defined different offences and developed different prosecution procedures as it depended on the state where it was applied as well as on the belief system of the accused (Nwamaka, 2011:156; Opafunso & Adepoju, 2016:2).

Yancey (1987:95) highlights the similarity in the classifications of offences in Nigeria to that of the United States. He attributes this to the fact that Nigeria used the American Constitution as its prototype when it drafted its 1979 constitution. Nigeria also embraces similar terminology to the United States of America such as that of felonies, delinquencies, and “simple offenses”. There is a distinction between federal felonies and state felonies in Nigeria. The Attorney-General of the Federation will prosecute in the case of a federal offence as well as where there is any infringement on an Act of Parliament or an offence against a military decree. Similarly, the Attorney-General of the State will prosecute on a state offence. Similar groupings figure out which court will hear the case. There is also a distinction in the classification of criminal offences in the North and the South.

The Nigerian CJS, according to Ukwayi and Okpa (2017:17), is an embodiment of crime regulating techniques. For one to be able to determine how effective a CJS is, one has to quantify its capability to deter, incapacitate, rehabilitate, and reintegrate the detainee in a manner that allows for him/her not to return to crime. In order to achieve the above, there has to be vociferous inter-collaboration between the different components of the CJS. Unfortunately, the high figures of detainees awaiting trial in detention in Nigeria have questioned the effectiveness of the Nigerian criminal justice system. Ukwayi and Okpa (2017:18) state that the CJS in Nigeria is not malleable, unbiased, and open to new ideas like that of developed countries. The standard practice internationally, is that people arraigned for petty crimes like traffic rules violation, non-serious fighting, among other minor crimes, are diverted away from sentencing to a correctional facility or given an alternate sanction, such as being given a fine. Petty infractions by detainees are taken seriously in Nigeria and often these people are imprisoned, thus leading to approximately 80% of the detainee population consisting of awaiting trial detainees who have committed petty crimes, that should be eligible for bail (Ukwayi and Okpa, 2017:18).

Nigeria is failing to cope with maintaining its laws in the midst of an overwhelming multitude of criminality (Amnesty International, 2008a; Olonisakin et al., 2017:34; Weimann, 2010:84). Nigeria experiences many religious and ethnic tensions (Central Intelligence Agency, [sa]). Many human rights violations still take place,

and this is worsened by the insurgency in the Northeast of the Boko Haram (United States Department of States, 2014:1). Serious human rights violations by the Boko Haram and its breakaway group Islamic State - West Africa included attacks on civilians, ethnic, regional violence, displacements of people, rape, looting, and destruction of property, religious violence amongst others (United States Department of States, 2017b:2) as well as cruel, inhuman and degrading treatment by the Nigerian security forces (Amnesty International, 2014:5).It appears that corruption occurs on a grand scale and at every point of the CJS from capture, to investigation, trial, prosecution in court, judgement, and execution of court judgement. Therefore, it is difficult to control systems to uphold the rule of law in Nigeria. Furthermore, primary role-players in the CJS, such as the Economic and Financial Crime Commission (EFCC), the Federal Road Safety Commission (FRSC), the Police, the judges, and corrections, are often said to be entangled in incompetence, corruption, and "injustice" (Olonisakin et al., 2017:34). Anaedozie (2016:12-16) emphasises that this has been a stumbling block in Nigeria's goal to realising "transparency, accountability, effective rule of law, national development and security".

Nigeria does not fare well in that it is negatively received by external communities. It was placed as the 148th most corrupt country out of the 180 surveyed by Transparency International (2018). In addition to this, it was found that Nigeria is the 4th least nonviolent country in Sub-Saharan Africa (Institute for Economics and Peace, 2016:13).

The Nigerian Police Force was only formed in 1930. Also termed the "gatekeepers of the CJS", the Nigerian Police is a paramilitary federal (national) establishment which functions under the control of the President of the country but under the command of the Inspector-General of Police. Each state has its own Commissioner of Police who is subject to the authority of the Inspector-General of Police (Federal Republic of Nigeria, 1999:93). Responsibilities bestowed on the police as recorded in the Nigerian constitution include the opening and investigation of criminal cases, making arrests, detaining offenders, and setting in motion the case. Olonisakin et al (2017:35) stand steadfast in their belief that the

Nigerian police are plagued by unethical behaviour which is in contrast to their reason for existence.

In Nigeria, the criminal procedure is founded on an adversarial approach, as is the case in South Africa. The burden of proof lies with the accused (Stephens, 2018:39). The Nigerian law specifies that an accused person must appear before court within 24 hours after being arrested (Ukwayi & Okpa, 2017:19). The Nigerian Supreme Court as well as the Appellate Court reports that the "holding of charges" is unlawful and prohibited. Failing to charge a person within the stipulated period brings to the forefront one of the challenges being experienced by the Nigerian CJS. The problem arises from the police's incompetency to implement the 24 hours proviso.

In Nigeria, as in the United States and in South Africa, criminal trials are usually brought by the state. The courts in the country include State Courts and Federal Courts. Federal Courts consist of the Supreme Court, Federal High court, and the Court of Appeal (Stephens, 2018:40). The Supreme Court, which is the highest court, is ruled by the Chief Justice of Nigeria and 15 justices. The President of the Court of Appeal leads the Court of Appeal and in its constituency must include three or more Justices of the Court of Appeal who must be learned in both Sharia law and customary law. The Federal High court is headed by the Chief Judge (Federal Republic of Nigeria, 1999:100-107).

There are courts specific to Abuja, which is the Federal Capital Territory, namely, the High Court, the Sharia Court of Appeal (headed by a Grandi Kadi of the Sharia Court of Appeal), and the Customary Court of Appeal (Federal Republic of Nigeria, 1999:107-110). The State Courts consist of a High Court, headed by the Chief Judge of the state; a Sharia court of Appeal; and the Customary Court of Appeal under the leadership of the President of the Customary Court of Appeal (Federal Republic of Nigeria, 1999:111-115).

The Nigerian Prison System (NPS) is modelled after the British system and falls under the Ministry of Internal Affairs with its Headquarters in Abuja, as a unified national structure (Stephens, 2018:41).

Although there was slight dishonour associated with imprisonment in Nigeria, it was unclear if this has had any preventive effect. Imprisonment was common with the Nigerian courts who tended to sentence detainees to long periods. Detention facilities were severely overcrowded, and the only possible separation of detainees was in the male and female categories. Remand detainees were rarely separated from the convicted detainees, and neither was provision made for special categories of detainees such as the mentally ill or juveniles (Coldham, 2000:220).

It must be noted that imposing fines was seen as low-cost penalisation as well as an effective deterrent, however imposing it on an underprivileged detainee who may not have the means to pay could end in jail time. Coldham (2000:221) supports this claim by indicating that a substantial percentage of detainees consisted of those who failed to pay their fines. Corporal punishment was extensively used as an optional punishment, either in place of another punishment, or it could be added to an existing penalty. It was regularly administered to juveniles. Physical punishment of adults was completely phased out in the East in 1955. Criminal law was seen as a harsh penalty for social control (Coldham, 2000:221-223).

The Controller-General is the accounting officer of the NPS and controls six Deputy Controller-Generals. The NPS had 234 detention facilities with an average detainee population of about 71 522 on 19 March 2018 (Walmsley, 2018a). According to Chukwuemeka (2010:114) and Obioha (2011:97), the NPS remains one of the most undeveloped agencies in the CJS, with the military not giving a thought to developing its infrastructure or improving detention conditions or even physically posing an obstruction to the daily responsibilities of the staff. The media is rife with negative reports of what takes place in Nigerian detention facilities. Staff are alleged to involve themselves in corruption, pilfering from detainees, setting aside of VIP cells for detainees that can pay for the service, rape, maladministration of funds, and illegal release of detainees (Olonisakin et al., 2017:36). This is attributed to the Nigerian corrections staff receiving one of the lowest salaries in Africa and in some cases receiving insufficient or irregular payment of remunerations (Chukwuemeka, 2010:114-118). However, reforms in

2007 with regard to conditions of service of staff were regarded as positive, and prevented a mass exodus of staff, thereby reinforcing security. These reforms did not however address the needs of detainees (Chukwuemeka, 2010:120).

Conditions in Nigerian detention facilities as outlined, makes it challenging for them to function as a means of attaining their rehabilitative goal. Of the 234 detention facilities in Nigeria, approximately 200 were built pre-1960, and detainees were accommodated in facilities that that are antiquated and unfit for humans (Olonisakin et al., 2017:37).

2.6.2 History and Theory of Correctional Systems in Nigeria

The history and theory of Correctional Systems in Nigeria, including the management of the mentally ill will be discussed over two periods i.e.. the period pre-1900 (pre-colonial period), and the period from 1900–1999 (during military rule). Post-1999 is a period when civilian rule emerged in Nigeria and this will be elaborated on in Chapter 3 to include the current management of the mentally ill.

Prior to 1861, some pre-colonial societies in Nigeria, such as the Tivs, Ibos, Edos, Fulanis, and the Yorubas, confined and incarcerated criminals, in some cases until the detainees were sold into slavery or placed in open areas for others to taunt them. It must however be noted that in traditional Nigerian society, imprisonment was not for punishment but for detention purposes only (Stephens, 2018:105).

Onyekachi (2016:3) maintains that before the arrival of the British, individuals who broke the rules and laws of society were hanged, beheaded, maimed, stoned, drowned, burnt alive, ostracised, exiled, and fined, and in other cases, humiliated. Precise punishments were meted out for certain offences. The sanctions of fines were given to those arrested for stealing, and the death sentence was meted out for unlawful killing.

Research points to the existence of a detention facility in Bonny situated in the Niger Delta in 1849, but there was not much documented on this. According to Orakwe (2017), the Controller of Prisoners of Nigeria, the modern detention facility

or what was termed the “Western style prison”, originated in 1861 when Lagos was declared a colony. The colonial government, in particular the acting governor of Lagos, focused on the security of trade in an effort to maximise the profits of the British merchants and to guarantee the business endeavours of the missioners. To accomplish this, a police force of approximately 25 officers was formed and with this, four courts in Lagos.

A detention facility which was constructed to house 300 detainees, namely the Broad Street prison, was established in 1872. The prison decree that approved the building of detention facilities was passed together with the Supreme Court decree in 1876. Thus, the administration of detention facilities began in 1876 as soon as the regulations came into force. Yet, the police department ran and managed detention facilities from 1876 to 1920. By 1920, the police’s administration of the detention facilities came to an end (Onyekachi, 2016:1).

The British did not recognise the traditional systems of confinement, and standards set by the British were difficult to adhere to. There was also at this stage no guiding policy document. The Broad Street detention facility was overcrowded by 238% and this became a problem in most colonial detention facilities (Stephens, 2018:106). The British, for the very first time, pioneered Western-style handling and treating of mental illness in the late nineteenth century, in response to a seeming multitude of “lunatics” on the streets (Westbrook, 2011:401).

The entire Nigeria area was by 1906 brought under one British rule. This, however, did not lead to a unified Nigerian Prison system. A major feature of colonial-era detention facilities was that it was intended to reform detainees. Detainees were utilised for labour in public works and other jobs required by the colonial administration. The colonial administrators therefore felt that there was no way to recruit trained officers and at times used the police and ex-servicemen to perform detention duties (Orakwe, 2017). There was no policy that governed penal administration, and this led to very poorly run detention facilities with very poor health and sanitary conditions.

The Prison Regulation was gazetted in 1917 to regulate the “admission, custody, treatment and classification” of detainees as well as staffing, food, and clothing for the detainees. They did not regulate any specifics with regard to the treatment of detainees but embodied fair policies of control of those who were imprisoned. Two general categories of detainees were in existence and the regulations were confined in application to those who were sentenced or those who were remanded by criminal courts of the British. Those remanded or sentenced by the Native courts were directed to the Native Authority detention facilities and were not supervised or inspected by the British. Although the regulation stipulated the categories of detainees to be found in each type of detention facility, its application to the National Prison only, led to the preventing of the NPS’s progress towards a national corrections service with standardised policies for the treatment of detainees (Orakwe, 2017).

Conditions in detention facilities varied from one facility to another and depicted the inefficiency and mistreatment of detainees to such an extent that it led to fatalities in the fcaility. A commission of inquiry set up in 1920 to investigate nutrition and matters affecting the health of the detainees in the southern province, found that there was no provision for seclusion accommodation for detainees infected by communicable diseases. It was only in 1926, that cells for isolated cases were built in Kaduna and Jos detention facilities (Stephens, 2018:107).

In 1934, significant effort was made to initiate transformation into the Nigeria Prison Service. Mr Dolan, a trained prison officer with a huge amount of experience in detention administration gained in Britain and in the colonies, succeeded Colonel Mabb in 1946. He continued bringing about significant transformation in detention facilities as well as recognising the Prisoners Warders Welfare Board. Although a system initiating vocational training in National detention facilities came about in 1917 it was futile, except in Kaduna and Lokoja facilities (Orakwe, 2017).

Mr Dolan re-tabled vocational training in 1949 as a principal part of incarceration in Nigeria. His approach to detention was progressive, as he made the categorisation of detainees binding in all detention facilities and introduced a

privilege system (visiting rights) to detainees. He also initiated the progressive earning of credits for those first offenders who were sentenced to long terms. He was instrumental in relocating the prison headquarters from Enugu to Lagos, to enable close collaboration with other departments of state. Mr Dolan believed in moral upliftment of detainees and brought about change with regard to adult education classes from a Christian and Islamic education point of view (Orakwe, 2017; Stephens, 2018: 108). Recreation and relaxation programmes formed part of the rehabilitation of detainees, and in light of this, he created the association for the rehabilitation and care of released detainees.

Orakwe (2017) attests that Mr Dolan was key to women working in detention facilities, by ensuring that educated wardresses were appointed to manage female wings of the facilities. In 1948, he opened four reform schools in Lagos. He believed that juveniles must be accommodated separately from adults and this resulted in him converting a wing of the Port-Harcourt facility for the accommodation and treatment of juvenile detainees. Mr Dolan was so steeped in the rehabilitation of detainees that he built an open detention facility in Kakuri - Kaduna in 1953. This was for first offenders who were serving long sentences (15 years or more), and who had committed crimes such as murder and manslaughter; they were to receive minimum supervision whilst undergoing training in agriculture. He prepared detainees for gainful employment upon release. He was, as stated by Orakwe (2017), key in the advancement of Nigeria's prisons service. Despite all the contributions towards reform, the management of mentally ill persons remained bleak.

The debates about inadequate treatment for persons with mental disorders has been a reason for anxiety ever since colonialism. There was no special treatment for those suffering with mental disorders. The mentally ill were left without proper care and in most instances were confined in an asylum without the appropriate treatment. Westbrook (2011:402-403) supports this, by indicating that inadequate resources in the mental health sector was evident, in that it was only in the 1950s that consideration was given to the employment of a professionally qualified psychiatrist. Yaba Lunatic Asylum became Yaba Mental Hospital in the 1960s and started treatment using traditional medicine and healing. There was therefore a

need for the provision of suitable treatment and care to persons with mental illness. This led to the adoption of the Lunacy Act of 1958 by the British colonialists (Ude, 2015:2).

According to the Lunacy Act of Nigeria, a “lunatic included an idiot and any other person of unsound mind”. The definition had the potential for broad interpretation and as such, magistrates had great power to decide on matters of involuntary detention, thus resulting in unwarranted detention of mentally fit persons (Westbrook, 2011:404). The Act outlines the procedures involved in committing a mentally ill individual, which requires that a medical practitioner as well as a magistrate can conclude that a person is a lunatic. A person can be committed for a period of seven days for observation if a medic considers it essential. This does not need the consent/approval of a magistrate (Westbrook, 2011:406).

Prison Decree Number 9 of 1972 regulated the classification of different types of detention facilities as well as governed the establishment of detention facilities in Nigeria. Detention facilities were categorised as “convict prisons, divisional, provincial, lock-up prisons and prison camps”. A convict prison accepted all categories of prisoners, (those serving long and short sentences and criminals sentenced to life). Convict prisons also included those that were officially termed as asylums (Onyekachi, 2016:2). Yet the conditions in Nigerian detention facilities did not get any better – the lack of proper drugs and qualified medical personnel to take care of the mentally ill remained a constant threat to the wellbeing of detainees (Obioha, 2011:99).

The Nigerian Prisons Service was, prior to 1999, therefore, in disorder. The detention facilities were in an appalling state. Together with a 193% overcrowding rate, its dilapidated infrastructure has experienced centuries of inattention and has made the detention facilities comparable to that of being in hell (Chukwuemeka, 2010:114). The dreadful conditions under which detainees were held, such as filthy cells, unsatisfactory medical care, food provisions, or water, led to outbreak of infections, environmental polution, and an increased death rate among detainees. Nigeria lacked the implementation of the Mandela Rules which aim to guide policy implementers towards the standards for the treatment of detainees

(Saleh-Hanna, 2008:486). Authorities did not make a concerted effort to provide mental health services to detainees with mental disabilities, nor did they provide for separate accommodation for such detainees (Amnesty International, 2017).

With the political rule of the military over a period of 29 years, detention facilities were administered as places for retribution. Detention facilities were not attended to, and no consideration was given for the development of their failing infrastructure nor were measures put in place to improve the terrible conditions. Chukwuemeka (2010:114) notes that the purpose of the military visiting the detention facilities was to ensure that detainees were disallowed any measure of 'comfort'.

Civilian rule in 1999 brought with it a promise to restore human rights, respect for the rule of law, and amongst others, the reform of the justice system, which includes the detention facilities. It was only towards the end of the colonial period that some steps were taken to train and rehabilitate detainees (Coldham, 2000:220), and will be elaborated on further in Chapter 3.

2.7 THE UNITED STATES OF AMERICA

2.7.1 Criminal Justice System in the United States of America

The United States of America (USA) is comprised of 50 states with an estimated population of 329.3 million in July 2018 (Central Intelligence Agency, [sa]). The USA is a constitutional federal republic with Washington, DC as its capital. Its legal system at federal level is that of common law which is in turn grounded on English common law. The state of Louisiana is based on Napoleonic civil code whilst the legal systems of the state are based on common law (Central Intelligence Agency, [sa]; Plaatjies, 2005:146).

The USA also experienced colonisation by Great Britain but gained its independence on 4 July 1776. Initially, it comprised 13 colonies but soon gained 37 other states in the following two centuries. The two predominant harrowing experiences in the nation's history were the Civil War (1861-65) and the Great

Depression (1930s). The Great Depression led to a high rate of unemployment and thus an economic recession. The end of World War II and the Cold War in 1991, saw the USA leap out of its depression to steady upward growth becoming one of the wealthiest nations (Central Intelligence Agency, [sa]).

The criminal justice system in America aims to keep communities safe, to respect and give back to victims, and to rehabilitate detainees, so that they become self-sufficient and law abiding when they return to their communities. The CJS in the United States (US), is categorised into three, namely, the federal, state, and military (Stephens, 2018:21). The structure of the American CJS is distinctive and multifaceted and it varies from state to state (Lekalakala, 2016:83).

The USA police consists of various independent police departments who report to their specific department. Federal law enforcement agencies in the USA are charged with the investigation of infringements of federal laws in the entire US, although each of the states has its own criminal justice system i.e. a decentralised CJS (Plaatjies, 2005:146).

Police in the USA far outnumber members of other occupational groups in criminal justice and as the “gate keepers” of the CJS, the police are in a position to make very significant decisions about what will happen to persons who allegedly break the rule of law. Besides having a large police contingent, the USA justice system ensures that they are also the most visible and identifiable component of the CJS, as most perform their duties out of conspicuously marked patrol vehicles. Visibility is a foremost strategy in controlling crime (Kappeler, 2012).

The US court system comprises of a federal court system and the state court system. Each court is in charge of hearing specific kinds of cases, however neither is entirely autonomous of the other. The highest court is the US Supreme Court, and it consists of nine justices - the chief justice and eight assistant justices. The selection of the judges is determined by the President who nominates and elects the Supreme Court justices, but only after advice and permission from the Senate. Subordinate courts consist of the Courts of Appeal. The Courts of Appeal are made up of the US Court of Appeal for the Federal District and “12 regional

appeals courts, 94 federal district courts" in 50 states and territories (Central Intelligence Agency, [sa]).

The prison system in the USA comprises of jails and prisons. Jails accommodate criminals with a sentence of one year or less, and prisons accommodate detainees with a sentence of more than one year. There is a distinction between federal and state prisons (Plaatjies, 2005:150).

After offenders are sentenced, they are detained under the authority of a state or federal correctional facility. Offenders could serve a probationary term as a sentence, be placed in community corrections, be sent to a county jail, or be accommodated in a prison (Stephens, 2018:25)

Overcrowding is rife in American detention facilities and this is attributed to the mass incarceration policies as well as the fact that the state and federal detention facilities incarcerate sentenced detainees for long periods of time (Freudenberg, 2001:215).

2.7.2 History and Theory of Correctional Systems in the United States of America

Early punishment in the Americas was based on the "theory of retribution" and was conducted in public (Harvard Law Review Association, 2002:1842). Imprisonment was uncommon in the beginning of the 18th century, except for political prisoners, religious offenders, and those who were regarded as debtors.

The 18th century, especially after 1775, saw a transition from public physical capital punishment to imprisonment for the purposes of punishment (Barnes, 1921:36). Conventional methods were used to punish crime in America before the middle of the 19th century, however brutal methods were used in all English colonies besides Pennsylvania (Barnes, 1921:36).

Criminal justice theorists and academics have acknowledged three main eras in American history that contributed to the way that crime and punishment were

seen. These are the retributive (Post-Revolution), the utilitarian (Pre-Revolution), and the rehabilitative (Reform era). They all denote distinct but different ideologies concerning the reaction to crime, from archaic approaches, to clinical, to rehabilitative approach. James (2014) maintains that the punitive ideology appears to have pervaded the very fabric of the criminal justice system in the USA.

The Retributive era, also known as the Pre-Revolutionary era, referred to a period before prisons were established in the States. Those who committed crime were either put to death, or those who were not given the death penalty were banished to the American colonies (Karpinski, 2018). During the Colonial period, two types of institutions existed, namely, the jails (prisoners), and the “workhouses”. Workhouses were established in the 1550s (Karpinski, 2018). Jails were primarily used for the detention of alleged criminals pending their trial, and for the incarceration of debtors, religious, and political offenders as well as the small number of detainees who had received a penalty of imprisonment (Barnes, 1921:36). Mentally ill persons were customarily confined in prisons and jails during 1770 to 1820 (Torrey, Zdanowicz, Kennard, Lamb, Eslinger, Biasotti & Fuller, 2014:6).

The workhouses housed “vagrants and paupers” in an effort to keep them away from the streets. These workhouses or prisons were poorly maintained, and the wardens were inattentive to detainees' needs. It was common for people to die of diseases such as typhus, malnutrition, or other common illnesses (Karpinski, 2018). These workhouses did not accommodate criminals. The development of modern penology, according to Barnes (1921:36) was due chiefly to the contributions of West Jersey and Pennsylvania. It was believed that imprisonment should be used not only to punish crime but that this imprisonment should be of hard labour (Barnes, 1921:36-37). The early detainees were not essentially "houses of punishment", but somewhat commonly used as short-term holding cells (Karpinski, 2018).

As early as 1694, legislation which used “dangerousness” as a chief measure for imprisonment, allowed the incarceration in jail for the “lunatic” who would pose a

danger to society (Schon, 2019:291; Torrey et al., 2014:9). In colonial America, prisons and jails were usually used to detain the more violent mentally disordered persons, and those who were not violent, would ordinarily be kept at home (Hatcher, Toldson, Godette & Richardson, 2009:6). However, even the families of the "lunatics" did not want them at home, and paid to have them confined. Because of the implementation of poor regulations, it became normal to detain the mentally ill. Consequently, prisons and jails predominantly incapacitated the mentally ill without treatment and care (Jacobs & Steiner, 2016:115). A New York Statute in 1790 also speaks of early confinement of the mentally ill in jails and prisons, which called for the "safe locking up" of such persons with no time limits to the confinement (Jacobs & Steiner, 2016:116.)

There were protests from many in the colonies in the early days on the inhumaneness of detaining mentally ill persons in prisons and jails. This led to America's first psychiatric ward in the Pennsylvania Hospital in Philadelphia in 1752. Then, in 1773, America's first psychiatric hospital, solely for the demented, was built in Williamsburg (Torrey et al., 2014:9).

The colonies in America publicly displayed gruesome punishment such as public whippings, humiliation, mutilations, and even castrations as a way to discourage others from committing crime (Barnes, 1921). This served more as a deterrent and means of conformance to the rule of law. Even the least serious of crimes were punishable by physical punishment or a fine for just about whatever was considered to be offensive, and these included not attending church regularly, stealing, lying, and even kissing your wife in public (James, 2014; Karpinski, 2018[sa]). Capital crimes were punished by death whilst non-capital crimes were punishable by corporal punishment (Barnes, 1921). There were differences among the colonies as well within the rest of America on what was regarded as capital punishment (Barnes, 1921).

Prisons up until the 18th century, were used mainly as detention for those accused of committing an offence against religion. These detainees were detained for a short period till a ruling was ordered. The lack of detention facilities during this time was a deliberate effort to keep detainees productive with

agriculture so as to sustain the survival of colonies (James, 2014). In the late 1700's, there was a shift in thinking in response to a scientific revolution. This was commonly known as the "Age of Enlightenment". French thinkers such as Montesquieu, Voltaire, and Diderot, and the essay by the Italian Cesare Beccaria's on *Crimes and Punishment,* were all critical of the death penalty and started debates on whether people should still be punished for crimes against religion or rather be judged by the deeds that were contrary to the safety of the community. There was an eventual shift from the utilisation of detainees for agrarian reasons to that of industrial reasons (James, 2014). There was a move to the thinking that being imprisoned was punishment in and of itself, and detainees need not be subjected to capital nor corporal punishment.

The Post-Revolution era, also referred to as the utilitarian era, saw the introduction of changes to the way imprisonment was looked at in America. The Industrial Revolution, the liberation of slaves, and the flood of immigrants into America, together with the increase in criminality, led to detention fcailities becoming places for punishment. Bentham was instrumental in changing from retribution to deterrence, because he believed that criminal conduct was the product of rational choice and that "pleasure and pain" could be used to limit choices made by individuals. Detention facilities suited this purpose because sanctions could be made proportionate to the severity of the crime (Harvard Law Review, 2002:1842).

Bentham designed a model detention facility without bars or guards which he called the "Panopticon". The Panopticon was designed in such a way that it allowed a single warden who was placed at the centre to see into all cells concurrently. In 1786, America began to evaluate its prison system, and started debates on its failings, its treatment of detainees, and the possibility for improvement. This led to the formation of prison reform societies (Karpinski, 2018).

It is not clear in literature where exactly the first correctional facility was established in America. However, several sources indicate that it emerged from the merging of the Pennsylvania System and the Auburn System. The Pennsylvania system (1829) was a system of solitary penitence that did not

believe in corporal punishment, whilst the Auburn system started in the 1820s as an adaptation to the Pennsylvania system in that detainees worked silently together during the day but were held in solitary detention at night (James, 2014; O'Connor, 2014:19; Williams, 2014). Discipline was maintained by enforcing inflexible rules around labour, silence, and discipline. The Auburn system was looked on favourably because of its classification system of detainees according to their crimes and it was able to produce its own income through its offender labour (James, 2014). This system later included separation of detainees according to their age, gender, and crimes, and thus the establishment of more "humane facilities and mental facilities" (Jacobs & Steiner, 2016:116).

The South began to vigorously apply the principle that the slaves were meant for hard labour and they should be utilised to make money for the state. The South thus started the leasing system where detainees were sent throughout America to perform labour. Squalid conditions existed and there was no regard for humane treatment of such detainees (James, 2014). This resulted in high mortality rates of "Negro" detainees. Enquiries into this called for discussions around "punishment vs rehabilitation" (James, 2014). With the Industrial Revolution there was an increase in societal ills. One being the increase in crime. It was therefore agreed by the penologists that a change in the approach to penitentiary was needed (Harvard Law Review Association, 2002:1843). Correctional facilities engaged treatment experts to resolve the problems fundamental to detainees' criminal behaviour. By the mid-19th century, policymakers and corrections officials developed moral training by instilling detainees with social and moral values as well as programmes to prevent reoffending, in an effort to rehabilitate and reform detainees. Such programmes included psychotherapeutic treatment, social responsibility, communication, and visits to detainees (O'Connor, 2014:23). Lawmakers amended the criminal codes to support the change in punitive theory, to incorporate indeterminate sentencing as a means of fostering rehabilitation. This was used as a criterion for eligibility for parole (Harvard Law Review Association, 2002:1843). This ultimately led to the birth of the Federal Prison System (O' Connor, 2014:23).

The developments in behavioural science offered clarifications for unethical behaviour. The Progressives claimed that customised treatment for individual detainees would cure criminal behaviour and avert imminent crime. The Progressive era would therefore improve on the treatment of the mentally ill, if indeed treatment existed, as well as provide psychotherapeutic treatment for detainees. In addition to this, the environment would be improved upon to create a more community-oriented atmosphere in detention facilities, and privileges such as communication with family and visits by family members were allowed. It was through the efforts of the Progressives that the Federal Prison System was produced (Morris & Rothman, 1998).

Alexander Maconochie designed a credit system which endorsed the idea that individuals can earn their liberty if they "worked hard" and were well behaved. The system was later extended to include advancing through various stages in order for the detainee to receive a "ticket-of-leave" to return to the community (James, 2014).

In 1841 Dorothea Dix campaigned for moving mentally ill persons out of detention facilities into improved treatment accommodation because she believed that decent treatment and cure for mentally ill persons was impossible in correctional facilities and jails, and the officials in correctional facilities and jails are neither capable nor taught to provide such treatment (Torrey et al., 2014:10). In 1881, through Dix's efforts, Massachusetts legally recognised "voluntary admittance" to a mental health facility (Jacobs & Steiner, 2016:116) and by 1880, there were 75 psychiatric hospitals in the US. The majority of the mentally ill persons who were detained in correctional facilities and jails had been relocated to the hospitals. The outcomes of the 1880 federal census in America revealed that merely 397 "insane persons" were confined in prisons and jails, among a prison and jail population of 59 006 (0,7% of the population) and of the rest of the 91 959 "insane persons, 41 083 were home-based, 40 942 were in hospitals, and 9 302 were in almshouses (Schon, 2019:273). By 1924, "voluntary admittance" was applied in 24 states in America (Jacobs & Steiner, 2016:116).

This state of affairs began to rapidly decline, and the numbers of mentally ill being detained in corrections and jails started to increase once again. This can be attributed to The Mental Retardation Facilities and Community Mental Health Centres Construction Act of 1963. This Act resulted in the downscaling of state hospitals. The Omnibus Budget Reconciliation Act of 1981 cut down direct federal funding to mental facilities and block grants were being allocated to the states. This resulted in a budget cut of 25%. These policy actions ultimately led to the closure of many federal community treatment centres (Hatcher et al., 2009:6). This aspect, amongst others, will be discussed in the next chapter.

2.8 CONCLUSION

It can therefore be concluded that the CJS process involves identifying, arresting, prosecuting, deciding on matters, and punishing members of the public who infringe its laws (Ukwayi & Okpa, 2017:17). The CJS also determines the appropriate punishment to be meted to the law breaker. The collective institutions of the CJS are composed of three major components which further consist of one or more public institution(s) such as the police and law enforcement agencies; adjudication in the form of courts; prosecution and defence lawyers offices; custodial institutions and corrections (Stephens, 2018:16). Corrections, being at the tail end of the CJS, has a responsibility towards keeping the society as well detainees safe through provisioning of probation, parole, and custodial functions (Frase & Weidner, 2018).

With regard to the historical development of prisons, it is clear that in the beginning of the 17th century, people believed that the actions of man were controlled by some external “super-power” and that no-one commits crime of his own free will (Velmani, 1991:2). Then changes in imprisonment came about, and the state took control of punishment (Faqir, 2015:3).

The use of torture and an extensive array of dehumanising punishments such as lashing, dismemberment, and public killings was common (Glory, 2012). The concept of the right of the king and the supreme authority of the monarchy was held in great reverence. The right of society to penalise the wrongdoer by torture

and pain was, however, well accepted. The fear of punishment at the hands of a ruler was an adequate deterrent to keep people away from committing sinful deeds, which were tantamount to crimes (Glory, 2012). Retributivists and the deterrent philosophers maintained that an detainee ought to be punished for his offending behaviour and to set an example to deter him or others from committing crime. Imprisonment is most applicably regarded as a formal perspective of imposing pain on individuals, this being a feature of the traditional CJS in many societies (Obioha, 2011:95).

During the 18th century "Enlightenment period", there was a focus on reform of the administration of the criminal justice system and more importance was laid on the state of mind of the individual (Glory, 2012; Tomlinson, 2016:33; Velmani, 1991:3).

The 19th and 20th century saw criminologists looking at the scientific view of human behaviour. This is clearly seen with the introduction and recognition of the new classifications of detainees, such as that of habitual criminals and mentally ill detainees. It has also laid the foundations for the use of psychology, including psychoanalysis, in studying the responses of criminals to various sentences and sanctions, and has opened up new approaches to finding solutions to the problem of integrating detainees back into society.

CHAPTER 3

MENTALLY ILL DETAINEES WITHIN THE CRIMINAL JUSTICE SYSTEM

3.1 INTRODUCTION

Governments across the globe must provide for legislation and policy to ensure systems work interrelatedly to guide societies attain governments' programmes of action. There are other critical issues that need to be addressed in such legislation and policies, apart from the protection of human rights. These include the improved access to treatment and care, improved treatment and care, the promotion of mental health in detention facilities, provision of therapeutic programmes, and partnering with stakeholders and other government departments for after care. It is the desire that the ultimate goal of any health system would be the reintegration/acceptance of mentally ill persons into the community. All of the above are espoused in the various countries' legislation and policies but the reality is that practice does not match what is written on paper.

The World Health Organization (WHO) has voiced its concern that international covenants and standards do not specifically address the rights of mentally ill persons uniformly, and has therefore developed ten basic principles in 1996 called the Mental Health Care Law: Ten Basic Principles. In addition to this, the WHO has developed a checklist that can be used by countries as a guide in the development of their legislation and/or policies whilst still using the international covenants and standards (World Health Organization, 2005:15-147; Zarret, 2016:210).

Mental health legislation is necessary to honour the rights of the mentally ill once he/she comes into contact with the Criminal Justice System (CJS). The CJS processes must be legally even-handed and impartial to those who have committed crime as a consequence of a mental disorder. Its legislation must ensure that it protects those that lack criminal capacity in order to avert the associated risk of abuse that mentally ill persons could be subjected to as a result of their mental disorder. Most progressive legislation and standards include

procedural protection for the mentally ill. Legislators, when drafting legislation, must accept that the mentally ill have neither control nor understanding of their conduct, nor are they able to comprehend court proceedings. The World Health Organization (2005:5), however, insinuates that legislation does not cover how the mentally ill should be managed. An analysis of the various countries' legislation will follow in this chapter.

3.2 CRIMINAL CAPACITY

Criminal capacity is defined as "being of sufficiently sound mind so that one may be found guilty of committing a crime" (Black's Law Dictionary, [sa]). The two main criteria that would render a person as lacking criminal capacity are (1) age and (2) mental disorder/illness/disability. It therefore stands to reason that the young and the mentally ill lack the mental abilities to either tell the difference between right and wrong, or to understand what is right and wrong (Badenhorst, 2006:37). Countries around the world have legislation to govern the degree of criminal responsibility associated with an accused person when the offence was committed. The indication that detainees who suffer from a mental disorder must be regarded or treated as ill and must therefore be excused from punishment dates back to ancient Greek and Roman law. The philosophy of this concept is non-deterministic (Salize & Dreßing, 2005:15). A mental disorder may weaken an individual's ability to distinguish between right and wrong and earnestly affect a person's free will. According to Salize and Dreßing (2005:15), "criminal responsibility" primarily stresses the judicial aspects of the mentally ill "problem" and "accountability" adds a medical connotation to it.

Many countries have based their legislation on the M'Naghten Rules of 1843. The M'Naghten rule is based on the premise that every person is "presumed to be sane" and has a sufficient amount of reasoning to be liable for his/her crimes until the opposite is proven. The onus is therefore placed on the accused to present evidence of insanity (Möller, 2011:44).

The Rules, which became the basis for assigning criminal responsibility and an insanity plea, were developed based on the belief that the capacity to choose

between what is right or wrong is the basis for legal responsibility (Abiama, 2015:59). These Rules permit a verdict of 'Not Responsible Due to a Mental Disorder' (NRDMD) on two conditions. Firstly, if the accused was not aware of what he/she was doing when the offence was committed and secondly if (s)he was aware of the offence but did not know that it was wrong. This therefore stands to reason that only persons suffering from a "defect of reason" were exempt from criminal responsibility (Möller, 2011:44). Those persons who fall in the second category of conditions for NRDMD are aware that their actions are wrong, but their reasoning is highly askew due to a severe mental disorder (World Health Organization, 2005:75). It is therefore debated amongst many that even the most severely mentally ill people are considered to be of sound mind under the M'Naghten Rules and are thus sent incorrectly to imprisonment. Such detainees have the right to consistent and periodic evaluation of their detention and the right to be given apt treatment and care in a therapeutic environment (World Health Organization, 2005:76).

Criticism has been levelled against the M'Naghten rule, as it is said that the rule is not in consensus with psychiatric knowledge and it does not allow for a holistic demonstration of the accused's state of mind, as it was not prerequisite that the evidence must be based on medical principles. Further to this, the psychiatric professional takes the role of judge and his/her evidence does not make a scientific contribution to the case (Möller, 2011:44). Salize and Dreßing (2005:15) articulate that the M'Naghten rule defined insanity as "intellectual incapacity".

Other countries base their legislation on the Durham Rule which requires psychiatrist evidence to prove that it was the individual's insanity which caused the criminal conduct (Möller, 2011:46; Robinson, Kussmaul, Stoddard, Rudyak & Kuersten, 2015:42). Further to these, the American Law Institute (ALI) introduced the ALI Test, also called the Model Penal Code Test. The ALI test specified that anti-social conduct did not determine the insanity of an individual. It stated that a defendant is "not guilty by reason of insanity" (NGRI) if it is established that he/she has a severe mental defect that affected his/her ability (at the time of the incident) to act within the law or comprehend that the offence committed was unlawful.

Such severe mental defects include retardation or schizophrenia (Möller, 2011:47).

3.2.1 Age of Criminal Capacity

“Doli Incapax” refers to the criminal responsibility of children. Common law supposes that a child above the age of 10 and below 14 years does not command the required knowledge to have criminal intention (Schoeman, 2016:36). The concept of “Doli Incapax” suggests that a child is unable to understand or distinguish his/her actions as being right or wrong. It also suggests that the child does not have the knowledge needed to have criminal intention and therefore ought not to be held criminally accountable for their actions. This distinction between right and wrong would require that the prosecutor must prove both the determinants of the offence, and must also prove beyond reasonable doubt that the child recognised and understood that what he/she did was criminally wrong as opposed to being naughty (Schoeman, 2016:36).

The age of criminal responsibility differs in the various countries being studied and ranges between the ages of 10 and 14. This is further discussed under the applicable legislations of each of the countries being studied.

3.2.2 Mental Disorder/Illness/Disability

Mentally ill persons are also categorised as “doli incapax” and therefore not liable for punishment in Roman law as well as Roman-Dutch law (Möller, 2011:2).

A court may find the accused “not responsible due to mental disorder” if the accused had a mental illness/disorder when the act was committed, the disorder was severe enough to impair self-restraint, the disorder hindered the suspect from understanding the wrongfulness of the crime (impaired reasoning) and the mental illness/disorder hindered the person from behaving in accordance with an understanding of the wrongfulness of his/her act (Möller, 2011:5).

According to Abiama (2015:59), the insanity plea is a legal argument used in court to not hold a defendant responsible for an illegal act because of a mental illness that impeded a person's rational thinking. It also includes not holding a person responsible if rational thinking was affected by something that caused that person not to see the difference between what is considered right and wrong. The insanity plea is rooted in criminal law, which articulates that people have a "freewill" and that if they commit crime, it is because they choose to and should therefore be held accountable for their actions and subsequently be punished by the law. The concept of criminal responsibility is based on the English Common Law and Doctrines of Equity. An offender who has committed an offence must understand the wrongfulness of the crime. Stated in Latin: "maxim actus non facit reum nisi mens sit rea", means 'that the intent and the action must concur to constitute a crime' (Abiama, 2015:59). According to Moore (2016:75), "mens rea" is a causal concept and refers to the mental element of committing the act and consists in a "blameworthy state of mind".

Further to this, the court should stipulate the release of the person back into the community, or order the admission to an appropriate facility for rehabilitation/treatment. It must be noted that offenders found not guilty due to a mental disorder should be subjected to treatment alternatives rather than being subjected to incarceration as a means of punishment.

Section B of the Nelson Mandela Rules places emphasis on "prisoners" with mental disabilities who are found not to be criminally responsible, or who are later found to suffer from severe mental disabilities/health conditions. Rule 109 and 110 specifically point to criminal capacity by stating that should continued incarceration mean the worsening of an detainee's mental illness, then he/she must not be detained in corrections but be relocated to mental health institutions. It however does make provision, that should imprisonment be necessary, then qualified health-care professionals must provide the necessary psychiatric treatment. It also necessitates psychiatric treatment be provided for all other detainees who are in need of such treatment (Stephens, 2018:224). Arrangements must also be made with community stakeholders for continued after care treatment (United Nations, 2016b:32).

In order to fully appreciate criminal capacity, one has to understand diminished responsibility. Diminished responsibility refers to the degree of “insanity” that is prevalent. A person may be mentally ill but still able to recognise and understand the criminality of his/her actions, and act accordingly. Such cases do not amount to legal insanity. However, specialist medical and other evidence is considered in deciding whether such a finding is justified (Möller: 2011:30).

3.2.3 Theories on Criminal Responsibility

Crime is socially and legally constructed. Both these fraternities decide on which behaviour is acceptable and which will be disallowed. This in effect means that behaviour which is contrary to good order must be punished, but before one is adequately punished he/she must be found responsible for the action. What then will render a person criminally responsible? And if indeed a person is criminally liable what extenuating considerations must be given to explain causality of criminal behaviour? The two competing philosophical frameworks that shed some light on this are the Free Will Theory and Determinism.

Free Will theorists believe that humans are able to exercise their free will and a sentient decision to participate in criminal behaviour, whilst determinists believe that our behaviour is ‘pre determined’ (Delaney, 2008).

Lombroso, a firm member of the positive school of criminology, identified physical features characteristic to criminal males and he believed in criminal behaviour as being deterministic (Ayugi, 2007:4). According to Hoefer (2016), causal determinism refers to the idea that every action is dictated by previous events and conditions, together with the laws of nature. Determinists are of the view that a person’s action is fairly “caused” by factors beyond an individual’s control, thereby advocating that individual behaviour cannot be separated from external, contributory forces. These causal factors vary from “divine intervention” to interfaces between social and biological influences, and may be hereditary as well as environmental (Jones, 2003:1034). Lombroso believed that there were three kinds of criminals. Those that were born criminals, the insane criminal, and the “criminaloids” who he named habitual criminals (Ayugi, 2007:5).

In contrast, Free Will theorists such as Beccaria, who is also known as the “father of criminal justice”, sees human behaviour quite differently. Influenced by the utilitarian philosophy, he maintained that man committed crime out of his free will and that wrongdoers should be punished swiftly and proportionally to the crime (Salize & Dreßing, 2005:15).

The Free Will theory purports that humans are born with the ability to choose or “not to choose” when faced by certain environmental stimuli. It thus follows that an offender has the ability to exercise his free will and “conscious choice” to participate in criminal behaviour. With this choice, the Free Will theorists believe strongly that the criminal can be held personally accountable for his/her choices, and thus should deal with the consequences for their decisions.

Jurists, such as Justice Holmes (1988), as cited in (Jones, 2003:1051), believed that from a legal perspective, if a person did not willingly and upon his/her free will, commit an act, that person cannot be held accountable for such an action because the factors that caused the action was outside his/her control. The action was determined, not by his or her own decision, but by genetics or the environment or nature. For a crime to take place there must be intent (free will) and since there is no free will involved, the legal responsibility for that act would be refuted (Moore, 2016:43).

Compatibilists with Neo Aristotelian views such as Frankfurt, Hart and Morse are of the view that people have free will provided that they decide and act according to and in relation to their needs, principles and intentions (Moore, 2016:44). Important considerations regarding free will in criminal law, is that a choice taken could lead to criminal sanctions and that a person could not be held responsible for an act he/she did not choose to commit. An individual should have the competence to be able to weigh the satisfaction derived from committing crime or of obeying the law. Therefore, the conclusion is that an effective system of criminal law must also include justifying conditions that reduce criminal responsibility. Such conditions refer to that of mental illness, coercion, and automatism (Moore, 2016:49). Courts therefore had the task to conclude whether an offence was performed through free will (with resultant punishment) or to

assess the extent to which it was influenced by a pre-determined frame of mind (such as mental illness which would ultimately require treatment) (Salize & Dreßing, 2005:17).

Kraepelin (1907), a German psychiatrist, as cited in Salize & Dreßing (2005:17) stated that consideration for treatment must be given to mentally ill detainees and if needs be, they should be exonerated from imprisonment, but cautioned that this should depend on their psychopathological condition. He also purported that the responsibility for a release judgement should be removed from the judges and courts to the psychiatrist. Kraepelin advocated that repeat offending or recidivism was strongly associated with a mental disorder and was a front runner for the integration of the theory of "diminished criminal responsibility" in the German Penal Code (Salize & Dreßing, 2005:17).

3.3 SOUTH AFRICA

3.3.1 Current Developments in South Africa – Post 1994

South Africa's first democratic elections in 1994 saw a new political party come into power. A new government, elected by the people, for the people, brought with it hopes of a new dispensation, based on recognising the rights of all South Africans and not just a select few. South Africa arose from the atrocities of apartheid, which included a disregard for human rights, freedom of movement, freedom of speech, and equal access to the country's services. This brought about many legislative changes and a new constitution (Central Intelligence Agency, [sa]; Republic of South Africa:1996).

The Department of Correctional Services (DCS) moved away from a military approach in their new Correctional Services Act 111 of 1998, towards a human rights approach in line with the Constitution and International prescripts. Policy was thereby amended to include the demilitarisation of the Department.

The Correctional Services Act 111 of 1998 placed greater emphasis on the rehabilitation of detainees, thus obliging the DCS to provide a wide variety of

programmes to detainees. A concerted effort was made to ensure that the Act provided for the detention of all detainees within a human rights culture. Many amendments to this Act were made in order to achieve this. Chapter 3 titled "Custody of all inmates under conditions of human dignity" was inserted by s3 of Act 25 of 2008 and directed that the minimum rights of all inmates should not be desecrated/restricted for punitive, corrective, or any other purpose. At the same time, it gives the authority to the National Commissioner of Correctional Services to limit, suspend, or amend amenities for the different categories of detainees.

With the dawn of a new democracy under the Government of National Unity, the DCS released a White Paper on the Policy of the Department of Correctional Services Corrections in 1994 (Department of Correctional Services, 2005:50; Singh, 2005:31). This policy document was based on the premise that detainees have the ability to correct their behaviours in a manner that will allow them to be accepted back into society, but it also placed the Department at the centre of providing a conducive environment for the detainee to rehabilitate him/herself.

The DCS has one National Head Office that determines legislation, develops policies and procedures for implementation at operational level. It has control over six regions (as opposed to nine provinces). These six regions are in control of a total 48 Management Areas, which in turn manages the 243 Correctional Centres for the detention of its detainee population. There are two Public-Private Partnerships (PPP's). Of the 243 detention facilities, 235 were functional, as at 28 November 2017, while eight were not functional due to repairs, upgrading, construction or dilapidation. Overcrowding and over utilisation of facilities remains a challenge, which impacts on operational strategies, service delivery, and meeting strategic objectives (Department of Correctional Services, 2018c:13).

The DCS plays a significant role in the Criminal Justice System (CJS). Discussions on re-engineering the criminal justice process emanated from the National Crime Prevention Strategy (Department of Safety and Security, 1996:7) to include the DCS's role in, amongst others, the rationalisation of legislation (Plaatjies: 2005:41). The CJS was reviewed (initiated by the Cabinet in 2007) in an effort to transform the CJS from a disjointed system that has no focus into a

fully competent and focused system that will not work in isolation but integrates its services with other role-players in the Justice Crime Prevention and Security Cluster (JCPS) so that value for money is obtained. The departments that constitute the JCPS are the Department of Justice and Constitutional Development (DoJ&CD), the South African Police Service (SAPS), the Department of Home Affairs (DoHA), the National Prosecuting Authority (NPA), the Department of Correctional Services (DCS) and Legal Aid South Africa (Legal Aid SA) (National Planning Commission, 2011:351). This is in fulfilment of the JCPS Delivery Agreement (Department of Justice and Constitutional Development, 2017:22).

The Constitution of the Republic of South Africa in Section 35 (2e) makes provision for every detainee's right to receive medical treatment should it be required (Republic of South Africa, 1996). In line with this, the DCS has encapsulated this in their mission statement: "Contributing to a just, peaceful and safer South Africa through effective and humane incarceration of detainees and the rehabilitation and social integration of offenders" (Department of Correctional Services, 2014a:1).

3.3.2 Legislations Governing the Management of Mentally Ill Detainees

The Constitution of the Republic of South Africa made provision for the existence of a public service in the Republic of South Africa (Republic of South Africa:1996). This public service must function structurally as a national entity with national legislation and aim to carry out the lawful policies of the government. In line with this, the DCS, was created by Section 7 (2) of the Public Service Act 103 of 1994. Its pronouncement is embedded in the Constitution; the Criminal Procedure Act 51 of 1977 referred to hereafter as the (CPA); the Correctional Services Act 111 of 1998; the Child Justice Act 75 of 2008; the White Paper on Corrections (2005) and the White Paper on Remand Detention Management in South Africa (2014). However the management of the mentally ill is guided by the Department of Health's related Acts such as the Mental Health Care Act 17 of 2002; National Health Act 63 of 2003; Nursing Act 33 of 2005; Health Professions Act 56 of 1974; and Medicine and Related Substances Control Act 101 of 1965. For purposes of

this study, discussions will be limited to the Criminal Procedure Act 51 of 1977 (CPA); the Correctional Services Act 111 of 1998 (CSA); and the Mental Health Care Act 17 of 2002. References will be made to the National Health Act 63 of 2003, and to other legislations and policies.

3.3.2.1 Criminal Procedure Act 51 of 1977

Mental illness is one of several factors recognised by South African law as nullifying criminal responsibility. The "defence of non-responsibility" in South Africa has conventionally depended on two things. The first being the age of an accused, and the second is whether the accused suffers from a mental illness or defect. A defence based on this, is referred to as the insanity defence or the defence of pathological incapacity (Grant, 2018:161). If an accused's argument is one of mental illness, the onus to prove it rests on the accused or the person/s who raised the issue as indicated in s78(1)(1B) of the Criminal Procedure Act 51 of 1997 (Republic of South Africa, 2014:54). If the defence is successful, the accused is not released, and usually ends up being committed to a mental health institution, either a psychiatric hospital or a correctional facility.

Persons who suffer from a mental illness lack the aptitude to appreciate the wrongfulness of their conduct and to act accordingly. Such persons are said not to be accountable for their actions because of their mental illness and therefore cannot be blamed for their conduct, as they lack criminal capacity, or their capacity is diminished (Republic of South Africa, 2014:53; Swanepoel, 2015:3251). The accused is then called a state patient.

The defence of mental illness has been governed by Criminal Procedure Act 51 of 1977 (CPA). Chapter 13 of the Criminal Procedure Act 51 of 1977 (CPA) addresses the "Capacity of an Accused to Understand Proceedings: Mental Illness and Criminal Responsibility". Sections 77 and 78 of the CPA makes provision for procedures to be followed in court when mental illness disrupts the criminal proceedings. It also includes processes involved in the custody of mentally ill remand detainees. It is therefore important to understand Section 77 and Section 79 of the CPA when discussing the mentally ill in the CJS of South Africa.

The Criminal Procedure Amendment Act 4 of 2017, which was assented to in June 2019, brought with it the amendments to Section 77(6)(a)(i) and 78(6)(b)(i), and provide that the court may order 'temporary detention' of mentally ill offenders, who committed a serious offence, in a correctional health facility until a bed becomes available in a psychiatric hospital. Prior to this, the accused could be detained in a psychiatric hospital or a "prison" (van der Haer, 2012:50).

The court can order an investigation, as indicated in Section 77 of the CPA if the court suspects that the accused is incapable of understanding the proceedings due to a mental illness and, if the court finds it in the public's best interest. This investigation is conducted to determine whether the accused is worthy of standing trial or not (Möller, 2011:10; van der Haer, 2012:50). The Act makes a distinction between offences that involve serious violence (murder, culpable homicide, rape) and those that are non-violent. If the accused is found "fit to stand trial", then the court proceeds in the ordinary way (Republic of South Africa, 2014:52). If the accused is alleged to have committed violent crime (murder, rape or culpable homicide) and is found "not fit to stand trial" they can be ordered to be accommodated in a psychiatric hospital (Swanepoel, 2015:3251). Prior to 2017, they would have been detained in a correctional facility but this since changed with an Amendment of the CPA in the form of the Criminal Procedure Amendment Act 14 of 2017.

If the court discovers that the accused has perpetrated a lesser offence or no offence at all, the accused is admitted to and detained in a psychiatric hospital. Such a person will be treated as an involuntary mental health care user (IMHCU) (Khan, 2017:40; Republic of South Africa, 2014:54).

Section 78 legislates criminal responsibility. Section 78(1) of the CPA states that no person who is suffering from a mental illness/defect shall be held criminally liable if he/she was unable to understand that what he/she did was wrong (cognitive defect) or to act accordingly (volitional/conative defect) (Republic of South Africa, 2014:53; Stuckenberg, 2016:54).

In terms of Section 78(2), the court may order an enquiry into the mental illness of a defendant if it suspects at any stage of the proceedings that the defendant may not be criminally responsible for the wrongdoing. The accused is committed to a mental hospital for 30 days for an investigation into his/her mental state. The report of the enquiry is regulated in Section 79 (Swanepoel, 2015:3249).

The court may, in terms of s78(6)(1), if the accused committed a serious violent crime, murder, culpable homicide, rape, or compelled rape, detain him/her in a psychiatric hospital or temporarily in the health unit/section of a correctional facility. This court order is made if a bed is not immediately available in a psychiatric hospital, and can only be made in terms of Section 47 of the Mental Health Care Act 17 of 2002. The detainee must be transferred as soon as a bed becomes available. The offender is treated as if he or she were an IMHCU whilst in detention (Republic of South Africa, 2017b:12). A court also has the options to order the accused's release, either on appropriate conditions or even unconditionally, or in the case of a child, refer the child to a Children's Court (Republic of South Africa, 2017a:7-8).

In other cases (non-violent cases), the court can order that the accused be detained in an institution and treated as if he or she were an IMHCU, be released either conditionally or unconditionally, or be referred to a Children's court (Khan, 2015:2).

The reasons for the examination into the mental condition of the accused are twofold. Firstly, the courts want to establish whether the indicted person is fit or unfit to stand trial (i.e. whether he/she is capable of understanding and following court proceedings), and secondly, if the person is criminally responsible for the crime (van der Haer, 2012:50). In South Africa, this assessment is conducted by a panel (in the case of serious violent crimes) or by a single psychiatrist. At this stage, the accused is either an unsentenced offender, a remand detainee, or an observation case. After the assessment and the report are submitted in writing, a determination will be made by the court. If the accused is found "fit to stand trial", then the court proceeds in the ordinary way. Should the accused be found "not fit to stand trial", the court then declares him/her as a State Patient or an IMHCU

(Szabo & Kaliski, 2017:70). The state patient and IMHCU is accommodated in a designated mental health institution or temporarily in a correctional health facility. If the accused is found not to have committed the offence, then he/she is admitted as an IMHCU. If it happens that the accused has committed the offence but is not criminally responsible, then the court proceeds in an ordinary way and the accused can be released, either conditionally or unconditionally. If the person was accused of a crime of a sexual nature with a minor, he will not be allowed to work with children. This is a stipulation of the Children's Act 38 of 2005.

In 1981, the Appellate Division, in the landmark case of *S v Chretien [*(S v Chretien 1981 (1) SA 1097 (A)], the accused was acquitted due to his level of intoxication. The argument was based on his lack of intention to drive into a crowd of people because he was intoxicated. This set the precedence for other 'non-pathological' conditions such as drugs and provocation to render one to be criminally incapacitated (Grant, 2018:161; Swanepoel, 2015:3248). Arguments and debates around the level of intoxication ensued, which resulted in the amendment of the legislature enacted Criminal Law Amendment Act 1 of 1988 which made it a crime when the accused's intoxication level was at a level high enough to render him/her to lack capacity (Swanepoel, 2015:3249; van der Haer, 2012:1). It is argued that "non-pathological criminal incapacity" does not result from a mental illness or mental disturbance (van der Haer, 2012:1).

The DCS' White paper on Remand Detention (2014b) acknowledges that some remand detainees placed in a correctional facility pending observation wait for more than two years for a bed to be made available, and state patients who are detained in remand detention facilities are "detained indefinitely" (Department of Correctional Services, 2014b:37). This therefore raises questions on the resource issues faced by both the Departments of Health and Correctional Services.

The CPA also makes provision for the expungement of records for certain crimes as indicated in s271B. It must however be noted that expungements do not apply to a mentally disabled person who has been included in the National Register for Sex Offenders. The record is expunged if his/her name has been taken out from the National Register of Sex Offenders, as laid down in Section 51 of the Criminal

Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007, or Section 128 of the Children's Act 38 of 2005 (Republic of South Africa, 2014:136).

3.3.2.2 Mental Health Care Act 17 of 2002

Health care in South Africa is provided by three sectors. These include the public health care, private health care and the non-governmental organisation (NGO) sectors. There are 22 psychiatric hospitals in existence in South Africa and 36 psychiatric wards in general hospitals (World Health Organization, 2007b:52).

According to the World Health Organization (2007b:52), South Africa has 3 460 outpatient mental health facilities which cater for 1 660 persons per 100 000 of the population in a year. There are 80 facilities which offer treatment during the day and 41 psychiatric inpatient units in public hospitals. 63 community residential facilities provide a total of 3,6 beds per 100,000 population; 23 mental hospitals provide a total of 18 beds per 100,000 population. One percent of all beds are reserved for children and adolescents in the various mental institutions across South Africa.

For purposes of this discussion, we will limit ourselves to that of the public sector, although detainees have a choice (as per their rights) to choose to be treated by their private doctors. NGOs do play a role in the provision of healthcare interventions in correctional facilities in South Africa. This too will be discussed in the next chapter.

Post-1994, South Africa aligned the country's mental health policies and service delivery with international trends in order to modernise the implementation of mental health through the national, provincial, and district structures (World Health Organization, 2007b:51). Two such efforts were firstly, the integrating of mental health into primary care, and the other, was deinstitutionalising care so that communities could be responsible for the care of the mentally ill, which is at the core of the Mental Health Care Act 17 of 2002 (Makgopa, 2017:1). This was a way of making primary mental health care reachable at district levels and at community level by having primary health care centres in the community. There

are wide disparities among urban and rural service provision resulting from limited resources and a burdened South African economy. This resulted in primary level clinics, support groups, even lay counsellors and community leaders getting involved where institutionalised help was unobtainable. According to the South African College of Applied Psychology (2019), only 27% of South Africans who report severe mental illness ever receive treatment for their conditions.

The term 'deinstitutionalisation' refers to a shift in mental health practice that speaks of moving mentally ill persons from psychiatric institutions to community-based facilities and treatment (Pillay, 2017:143). South Africa started “deinstitutionalising” its severely mentally ill in the mid-1990s. The Mental Health Care Act 17 of 2002 replaced the Mental Health Act 18 of 1973, and this saw a rise in the pace of deinstitutionalisation. This was not supplemented by the development of community psychiatry, adequate resource allocation, or the increase in specialised resources (Robertson, Janse van Rensburg, Talatala, Chambers, Sunkel, Patel & Stevenson, 2018:362).

The National Mental Health Policy Framework and Strategic Plan 2013 – 2020, recognises this disparity when it states that 'deinstitutionalisation” of the mentally ill increased the numbers of homeless mentally ill persons (Department of Health, 2013:16). There has been an associated increase in the numbers of people living with mental illness in corrections (Department of Health, 2013:16). The poorly planned deinstitutionalisation process with the relocation of so many mental health care users from Life Esidimeni to under resourced non-governmental organisations (NGOs) resulted in the termination of the last remaining long-stay beds (Robertson et al., 2018:362).

The DCS in South Africa provides primary health care. It makes provision for the “care, treatment and rehabilitation” of mentally ill “prisoners” in Section 51 of the Mental Health Care Act 17 of 2002 (Republic of South Africa, 2002:54). The Act dictates in Section 49 that health facilities must be established to take care of, admit, provide treatment, and provide rehabilitation services to mentally ill “prisoners” (Republic of South Africa, 2002:55). It also recognises that there must be the need to adopt and consider advancements in the mental health sphere in

order to provide efficient health services as part of primary, secondary, and tertiary health services (Republic of South Africa, 2002:1). The ten basic principles set out by the World Health Organization forms the basis on which this Act was developed (World Health Organization, 2005:119-154). The Act brought with it a more 'patient centred' approach to psychiatric care as well as changes in terminology, such as the term "patient" is now referred to as 'mental health care user' (MHCU), and the "psychiatrist" is now referred to as a 'mental health care practitioner' (MHCP) (Szabo, & Kaliski, 2017:69).

After an accused person has been affirmed as a 'state patient' under Section 41 of the Mental Health Care Act, he or she has to be transferred to a correctional facility, still on remand. In most cases, the process takes quite a while to be finalised and these state patients are left suffering in remand detention because the elected facility does not have sufficient beds to accommodate them (Szabo, & Kaliski, 2017:70).

The Mental Health Care Act does however make provision in Section 50, for the head of the correctional centre (HCC) to make an enquiry into the mental health of a suspected mentally ill "prisoner". The assessment should be conducted by a psychiatrist. In the absence or non-availability of a psychiatrist, then the assessment can be conducted by a medical practitioner and a mental health care practitioner. A subsequent enquiry must be done into the mental health of the offender which will be ordered by the court if it is recommended that the offender be relocated/transferred to a mental health facility to receive the appropriate care, if the correctional facility will not be able to do so. According to Szabo and Kaliski (2017:70) very few detainees are transferred, because there is a scarcity of psychiatrists (if any) working in corrections and this therefore undermines the aims of the Act.

It also provides processes for the transfer of a mentally ill offender to a mental health facility within 14 days of receiving the order for transfer from court.

The offender's mental status is reviewed every six months for possible transfer back to the correctional facility, and if the head of the health establishment

indicates that the offender has recovered to such an extent that care is possible at the correctional facility, then arrangements must be made for the collection of the offender by corrections authorities. Section 58 provides for the mentally ill detainee to be released on expiry of the term of imprisonment from a correctional facility or from a health establishment at which the offender is detained. Arrangements must be made with the HCC for assisted or involuntary care, treatment, and rehabilitation for the detainee (Republic of South Africa, 2002:55–61).

The Mental Health Care Act brought with it a focus on public mental health within a human rights ideology, a shift towards a more humane care for the mentally ill, and improved quality care. This is especially important for corrections systems that decided to move away from the custodial approach to one that encourages care in the community. Critics of the Mental Health Care Act, however, maintain that the Act has 46 associated forms, making it a cumbersome administrative process. Added to this, are the many challenges to the clinician, as the whole process, if it is to be administered properly, will require a huge budget. This therefore has repercussions for other resources in respect of suitable facilities and scarce human resources (Moosa & Jeenah, 2008:110; Szabo, & Kaliski, 2017:70).

People with severe mental disorders may possibly lack the capacity to take and make their own decisions with regard to treatment. Therefore, the Act makes provision for others to take decisions on their behalf (Jack-Ide, Uys & Middleton, 2012:51). The aim of the Mental Health Care Act 17 of 2002 is to prevent discrimination and the disrespect of rights. Yet, it is debated that being admitted involuntarily to mental health institutions facilities and involuntary treatment impinges on personal freedom and on the right of choice, which may open the mentally ill person to abuse in some form or another (Department of Health, 2012:4). Jack-Ide et al (2012:51) on the other hand, argue that involuntary admission could be essential in an effort to prevent self-harm. The issue of the possibility of injury to others does not take away the right of a person to take and make their own decisions with regard to treatment. The authors also state that the South African Mental Health Care Act 17 of 2002 aims to de-stigmatise and protect the mentally ill, in the sense that the review and appeal process protects

their rights as well as offers them a right to representation. The Mental Health Care Act 17 of 2002 also protects their right to appeal against decisions made by mental health care practitioners regarding their care (Jack-Ide et al., 2012:51).

Section 159B(4) of the Criminal Procedure Amendment Act 65 of 2008 made it possible for an detainee who is physically or mentally unwell to appear before a court through an audio-visual link. There has been an increase in the use of an audio-visual link in South Africa. However, the issues of operability of equipment seem to hamper the maximum use of audio-visual linked courts (Republic of South Africa, 2008:5). According to the Department of Justice and Constitutional Development (2018:33), 11 329 postponements were conducted via the Audio Visual Remand system in 2014/15 across 23 courts across the country and increased to 17 271 criminal cases being remanded using this technology in 2017/2018.

Burns (2010:662) argues that South Africa's resources are still insufficient to give impetus to the implementation of the Mental Health Care Act 17 of 2002. The challenges that are highlighted by the author include an aging infrastructure, extremely scarce mental health professionals, and communities that are not well equipped to render the necessary treatment and care (due to the rushed implementation of the de-institutionalisation approach).

3.3.2.3 Correctional Services Act 111 of 1998

The Correctional Services Act 111 of 1998 (CSA) was passed in 1998 and only promulgated fully in 2004. The Act established a "human-rights-based" structure for South Africa's correctional system and defined its purpose that of ensuring all persons under its care are detained in safe custody as well as ensuring their human dignity. In addition, to this the DCS correctional system intends to promote detainees' social responsibility, personal development, and integration back into society (Republic of South Africa, 2012).

The Correctional Services Act 111 of 1998 was amended several times in order to incorporate changes in legislation arising from transformation brought about by the new democratic order. Amendments effected were from the following: -

- Correctional Services Amendment Act 32 of 2001.
- Institution of Legal Proceedings against certain Organs of State Act 40 of 2002 [with effect from 28 November, 2002].
- Judicial Matters Amendment Act 55 of 2002 [with effect from 17 January, 2003 (unless otherwise indicated)].
- Correctional Services Amendment Act 25 of 2008.
- Child Justice Act 75 of 2008 [with effect from 1 April, 2010].
- Correctional Matters Amendment Act 5 of 2011.

The approach taken by the drafters of the CSA is that the minimum rights of detainees must be respected at all times and should not be used as sanction against the detainee at any stage. Such rights are inculcated in the humane treatment of detainees and as outlined in Chapter 3 of the CSA (Republic of South Africa, 2012).

The State Patients Protocol outlines the responsibilities of various role players of the criminal justice system on the management of state patients. While state patients are detained in correctional centres they must be provided with relevant health services including the provision of psychiatric treatment. The Department of Correctional Services has also worked collaboratively with the National Department of Health to improve the management of state patients (Department of Correctional Services, 2019a:19).

3.4 GERMANY

3.4.1 Current Developments in Germany – Post 1970s

The Federal Constitutional Court declared that the prison regulations of the federal states did not have sufficient legal basis for additional restrictions of detainees' rights, and commanded a uniform system be created in law. These changes in approaches to focus on detainee rights led to the development of the Federal

Prison Act of 1996, which was entered into force on 1 January 1977. The Act introduced rehabilitation of detainees as well as ensuring, as per Section 2(1) and Section 3 that detainees be incarcerated in a corrections environment, which is parallel and as similar as possible to the conditions outside of corrections (Vormbaum & Bohlander, 2014:237). This is termed as "the principle of normalization" by Subramanian and Shames (2013:7).

The prison system, which was one of the forbidden topics in the German Democratic Republic (GDR) in the past, started being spoken about when societal changes started taking place in Germany in 1989. Reunification of the GDR with the Federal Republic of Germany (FDR) in October 1990, and specifically the signing of the unification treaty, provided for the Federal Prison Act of 1977 to be enacted throughout Germany (Arnold, 1995:81). The West German authorities began preparing for this takeover of GDR organisations including the GDR prison system. This meant that changes and reconciliation with regard to structures, its management and mechanisms, and its legal regulations, as well as with respect to the detainees and the staff themselves had to take place. Other changes included the placement of prisons under the control of the Justice Ministry, as in the case of West Germany, or remaining under the Ministry of the Interior (East). Highly ranked military officials governed the Ministry of the Interior. Prisons in East Germany were managed on a police state model established by the Prussian government of the Weimar Republic (Arnold, 1995:81).

On 1 September 2006, federal law reform was applied by the German Parliament and with this, the transferal of competencies from federal to state level (Lehmann, 2012:131). The federal penal law thereby regulated the penal system and detention facilities were resultantly placed under the jurisdiction of the individual states of the Federal Republic. Each state had its own Ministry of Justice (Salize et al., 2007:154). One would therefore expect differences in the managing of penal institutions regionally.

This reform resulted in the Juvenile Detention Act of 2008 coming into force, and other legislations such as the Remand Centre Act of 2010, which was based on the premise of innocent until proven guilty, followed soon after. The Protection of

Data Act of 2011 was developed to provide guidance on data management whilst considering confidentiality prescripts of certain kinds of data such as detainee information; thus respecting the confidentiality rights of the detainee. The Preventive Detention Act of 2013 regulated those detainees who had already served their sentences but who still needed to be incarcerated as they still remained a risk for re-offending. The conditions that they were detained in were significantly better than those of regular detainees – this also included those with mental disorders. This will be discussed further in the next chapter.

3.4.2 Legislations Governing the Management of Mentally Ill Detainees

The Federal Republic of Germany is the largest country in Europe. Its capital cities are Berlin (since Oct. 3, 1990) and Bonn (West Germany, 1949-1990). Its population stands at approximately 80 million (Lehmann, 2012:131).

Germany being a constitutional democracy lays out the basic human rights in Article 1 to Article 19 in The Germany's Constitution of 1949 with Amendments through 2012 (Federal Republic of Germany, 2012:8-14). However, concerns are raised by Amnesty International of possible human rights violations. The first concern is on the fast-tracking of cases as a change in the National Security Legislation brought about after the 19 December 2016 attacks at a Christmas market in Berlin. Fast-tracking of cases could result in violating the right to a fair trial (Amnesty International, 2018:7). Secondly, a change was brought about by the Amendment Act on the Federal Criminal Police towards pre-emptive justice which allows for the arrest of persons without them being formally charged as well as the concept of a "potential attacker" which allows for the police to electronically tag and place under surveillance potential attackers (Amnesty International, 2018:7-8).

Mentally ill detainees in Germany are managed through distinctive legal regulations arising from debates in the late 1800s to the early 1900s but which culminated in the approval by the Nazis of the law on "Dangerous Habitual Offenders and their Detention and Rehabilitation Act" of 1933. It was a measure of distinctive preventive measures aimed at promoting public safety against the

anticipated threats committed by the mentally ill. The Act was amended in 2007 to include therapeutic concepts in the treatment of mentally ill (Konrad & Lau, 2010:237).

Mentally ill detainees are detained according to the perceived danger they pose either to society or to themselves. This detention is either voluntary or involuntary. The offender is voluntarily placed in a general clinical psychiatric hospital if he/she meets two criteria. These criteria include that the offender is perceived to be "not dangerous", and the other is that it must be established that the offender is affirmed to be "not criminally responsible" and therefore unable to stand trial.

An offender will be involuntarily detained in a forensic psychiatric hospital when he/she is perceived to be capable of committing further crime and subsequently poses a danger either to him/herself or to society as per s63 of the German Penal Code (Federal Republic of Germany, 2010:24). This offender must still be found unable to stand trial/affirmed to be not criminally liable or be found to have diminished responsibility. Germany's hospitals held 6287 detainees on 31 March 2008 (Konrad & Lau, 2010:237).

3.4.2.1 The German Code of Criminal Procedure (Strafprozeßordnung)

In Germany, the minimum age of criminal responsibility is not determined by the offence, but by the "age and mental development" of the youth or the young adult. According to Papadodimitraki (2016:2), a youth is defined as being someone who is 14–18 years old, and a young adult is someone who is 18–21 years old. The minimum age of criminal responsibility in the European Union (EU) member states is 14–16 years. According to Salize and Dreßing (2005:40), a generally low minimum legal age for criminal responsibility is an indicator of a strict legal system.

Section 19 of the German Criminal Code is clear that people who have not achieved the age of 14 when the offence was committed is not guilty of the crime committed (Federal Republic of Germany, 2010:7; Salize & Dreßing, 2005:41). This is in line with the United Nations Convention on the Rights of the Child (UNCRC) General Comment No. 10. Based on civil law, it is said that although

children under 14 are not held criminally responsible, they can be held accountable for reparations to somebody.

Age restrictions for prosecution do not apply for mentally disordered persons. Mentally disordered offenders are subject to distinct legal codes of practice. The forensic law of Germany is categorised by different degrees of criminal responsibility (i.e. Germany employs a graded concept of criminal responsibility). The offender either lacks criminal responsibility, has diminished criminal responsibility, or has full criminal responsibility (Salize & Dreßing, 2005:41).

Germany separates mentally ill detainees from the general detainee population pursuant to their distinct needs for treatment and/or the level of risk/danger they pose to the public. Detainees who are not criminally responsible and who are not a danger to him/herself or the public are hospitalised in a general clinical psychiatric institution. Detainees with diminished criminal responsibility are admitted to special forensic security hospitals under the control of the Health Ministry (Salize et al., 2007:155). All other disordered detainees who are criminally responsible, are sent to detention facilities, besides those whom are given a fine. Detainees who are dependent on substances that induce psychosis but whom have a good chance of recovery are sent to withdrawal facilities under the jurisdiction of the Minister of Health.

When an accused is suspected or thought to be mentally ill before trial, they can be placed in a general psychiatric facility and in terms of Section 60 of the German Code of Criminal Procedure an oath shall not be administered to someone who is unable to appreciate the importance of an oath because he/she is mentally ill or is "deficient in intellectual maturity" (Federal Republic of Germany, 2014:16). Germany also makes provision for the placement of an accused/detainee in a specialised forensic facility before the trial has begun.

A mentally ill accused/detainee could also be sent to a remand facility. German law also makes provision for a person accused of minor offences to be sent out on bail to their homes with the condition that they receive outpatient treatment (Salize

& Dreßing, 2005:43). There is, however, a limit of 12 months placed on pre-trial placement depending on the severity of the crime as specified by German Law.

Section 81 provides guidance in respect of the placement of the accused for observation to a public psychiatric hospital and not a prison detention facility. This order is only made when there is a strong case against the accused and this observation period may not go beyond 6 weeks (Federal Republic of Germany, 2014:21).

Germany, however, provides for separate legislation in the form of the Juvenile Court Act of 1923 when prosecuting and judging a juvenile detainee. In most cases, this means that the juvenile, even when indicted as an adult, will not necessarily be subjected to the adult penal framework. The Juvenile Court Act of 1923 provides a complex educational and correctional system for juvenile detainees (Salize et al., 2007:41). The case is held in youth courts, which have a less threatening environment. The judges and prosecutors that are tasked to handle the case are specially trained on children's issues (Papadodimitraki, 2016:2).

Social workers from the Welfare Department are instrumental when court proceedings commence. An assessment is conducted on the child's family background, development, school situation, historical conduct, etc. The purpose of this assessment is to determine the character, psychological, and emotional state of the child (Papadodimitraki, 2016:2).

In the case of less serious crimes, the case can be diverted or abandoned. If detention is ordered during the investigation, the child can be sent to the police or a prison but every effort must be made to place the child in a dedicated institution (or in a specific unit of the prison or the youth prison), if possible. Children may also be placed with adults (Papadodimitraki, 2016:3).

There are two registers, which have to be endorsed when a child is sanctioned in Germany, which are dependent on the age of the child. For children above the

minimum age of criminal responsibility, sanctions are registered on an Access Restricted Register.

Only youth sanctions are recorded in the Federal Crime Register. Further to this, the case is entered into an Educative Measures Register if the proceedings conclude with sentencing remarks or orders. These orders or sentencing remarks are not the final judgment. This is not part of the child's criminal record. This is done to prevent courts, prosecution and prison services, the police, tax authorities, and other organisations, from accessing children's information as they have unrestricted access to such information found in the criminal records (Papadodimitraki, 2016:4).

It is possible in Germany for a trial to continue in minor cases even though defence counsel has not been allocated to the mentally ill defendant. Courts are hesitant to allow a mentally ill detainee to defend him/herself (Salize et al., 2007:62).

3.4.2.2 German Criminal Code (Strafgesetsbuch)

The system of criminal punishments is measured in a bifurcated penal system, which applies incapacitative and rehabilitative measures (Reinke, 2009:120).

When discussing mentally ill and the German Criminal Code it is important to focus on the sections of the Code that speak to mental disorders as it is referred to in Germany.

The Code speaks of "insanity" in Section 20 and states that a person is not guilty of committing a crime if that person was not capable of recognising the illegality of their actions because he/she suffers from a "pathological mental disorder" or "any other serious mental abnormality". The Code further states that the law provides for mental disorder/abnormality to be used in the mitigation of sentences if diminished responsibility is proven. Thus, offenders who are guilty of crime but have severe diminished responsibility, and those offenders who are not guilty due to reduced incapacitation (NGRI), may receive a hospital order sentence (in terms

of Section 63) for admittance to their forensic psychiatry system. This is also considered a preventative measure (Dessecker, 2009). The hospital order is made only after a comprehensive assessment conducted by a professional concludes that the offender presents a danger to the public and is highly likely to re-offend (Trestman, Eucker & Müller-Isberner, 2007:230; Federal Republic of Germany, 2010:24). Imperative to understand, is that the commitment of persons with mental disorders to a mental institution is permissible only by a court order through administrative law of the Federal states and the Civil Code. Other than these two statutes, hospital treatment is only legal with a patient's consent (Dessecker, 2009). According to Konrad and Lau (2010:237), there are no special courts in Germany that are dedicated to mental disorders. It is the duty of regular criminal courts to execute those legal regulations concerning mentally disordered offenders and which are referred to in the Penal Code. For this purpose, "expert witnesses" are appointed either in the early stages of the investigation by the prosecutor or even by the court of law (Konrad & Lau, 2010:237).

With regard to informed consent under the Federal Civil Code, it was sufficient that a legal custodian could give permission for the kind of treatment one was to receive. A legal controversy around this ensued in 2012 subsequent to rulings of the German Supreme Court. New legislation was introduced in early 2013 that brought about changes with regard to the consideration of several and various factors before a legal custodian can agree to any type of treatment of a mentally ill person. One factor which was taken into consideration is that the affected mentally disordered individual must be admitted to a mental health care unit. The other is that he/she must lack the capacity to act according to the medical measures on his/her own. These measures are obligatory to avoid imminent impairment to the health of the affected person (Zielasek & Gaebel, 2015:15).

There are no distinctive diversion programmes in Germany. Diversion in Germany does occur in terms of regulations that are based on the concept of legal responsibility for the crime committed (Konrad & Lau, 2010:237). There are legal avenues which allow for the removal of mentally disordered detainees from the CJS at any stage of the court processes or court proceedings. This may result in the police mistakenly detaining a mentally disordered detainee in a psychiatric

facility instead of handing him over to an investigative judge. The prosecuting authority can drop the charges if it is obvious that the offender is not fit to stand trial, or he/she is deemed to be not criminally liable for the offence. This charge would be dropped if the offence does not pose a danger to the public (Konrad & Lau, 2010:237). Further to this, guilty detainees with severely diminished responsibility will be given a twofold sentence of a "determinate prison term" and an "indeterminate treatment in the forensic hospital". This indeterminate treatment is applied to those detainees who either lacked "mens rea" completely when committing the offence or that their criminal responsibility was diminished and who due to their mental condition are likely to reoffend. This must be determined on the basis of expert evidence that shows that the guilty detainee (who committed a serious crime) is a danger to him/herself or to the community if they are not sent for treatment (Zielasek & Gaebel, 2015:15). Diminished criminal capacity is also used as an extenuating factor in a criminal trial in Germany. It is also a reason to determine whether indeterminate detention would be executed/given. The other reason that indeterminate detention would be imposed on someone is if the public prosecutor cannot establish that person's criminal responsibility because of his "mental/psychological/psychiatric abnormalities", as they are termed in the German Criminal Code.

The time that is spent in the forensic hospital is deducted from the given sentence (up to two thirds in the case of a dangerous criminal) and if a discharge is ordered under certain conditions by the court, the remainder of the sentence is served under probation (Trestman et al., 2007:231). Detention usually lasts several years.

The lawful grounds for involuntary detention of offenders in a forensic psychiatric hospital are found in Section 63. It applies to individuals declared "not to be criminally responsible" as well as to those who have diminished responsibility for the crime (Council of Europe, 2017:41).

Section 64 of the German Penal Code makes provision for an order to be issued to offenders reliant on psychotropic drugs, for compulsory detention in special detoxification units in forensic psychiatric hospitals, provided that these offenders

can be treated from this addiction. The number of persons detained in such units was 2565 as of 31 March 2008 (Konrad & Lau, 2010:237). All those who are placed under Section 63 may be indeterminate whilst those placed under Section 64 may be ordered only for a maximum of two years (Council of Europe, 2017:41).

German criminal law (s67 of the Criminal Code) forces administrators to adhere to the principle that the offender must first be detained in a psychiatric hospital before serving his/her sentence. Non-adherence to this principle is allowed, but only in cases where the criminal court finds that the goals of psychiatric detention would be achieved more easily if the offender served all or parts of the prison term first (Zielasek & Gaebel, 2015:14). Offenders who are sent to psychiatric institutions and those serving "incapacitative sentences" are paroled once it is acknowledged and proven that they do not pose a danger to themselves or the community any longer. Therefore, a court reviews incapacitative sanctions every other year, and psychiatric detention every year, as indicated in s67e of the German Criminal Code (Federal Republic of Germany, 2010:28). This is also supported by Zielasek and Gaebel (2015:14) who state that if treatment is successful, some parts of the treatment process may happen in the community. This is often the last part of the treatment and must be complemented by regular visits to an outpatient forensic service. In 2015, approximately 500 persons were imprisoned under this law.

In addition, Section 67d(6) talks to the duration of detention, in that the court can dismiss the mental hospital order, if it discovers that the conditions for the treatment do not exist anymore, or that the continued treatment is no longer appropriate. Such a person would be subjected to correctional supervision, however, if the court believes that the detainee will not commit any further crime then the court will "waive supervision" (Federal Republic of Germany, 2010:27).

The abuse (sexual or other), the attempted abuse (sexual or other), or engaging in sex with a person who has a mental illness/disorder entrusted under the care of another (counselling, treatment or care), is a punishable offence. Detainees can be sentenced to a term of three months to five years. This is in line with Section 174c of the German Criminal Code (Federal Republic of Germany, 2010:86).

Germany, as an EU member, does not exempt mentally disordered persons from being placed in a prison, and care is made to legally regulate the sequence in which this happens. In Germany, forensic psychiatric placements are given priority and implemented before a prison sentence is served. However, there are exclusions to this general rule. The expected treatment result is a deciding element in determining the sequence. If treatment does not show a realistic positive and progressive result then the prison sentence could be ordered to be served first (Salize & Dreßing, 2005:46).

3.4.2.3 Mental Health Care (Social Code)

Germany's reform on mental health started approximately 30 years after World War II. However, progressive policies have been introduced since 1970, and currently follow a universal health coverage system which is compulsory (Campos, 2016:2-19). In this regard, Germany opened up psychiatric units in the general hospitals, and resorted to community-based services on a small scale. Due to political and social reform, resulting in the lack of resources (weak East German economy), psychiatric hospitals dominated mental health care services (Coldefy, 2012:5). Germany implements what is termed a catchment area principle. This means that the number of patients is confined to a specific geographical area in order to make mental health services easily obtainable/accessible as well as to prevent the overstraining of resources in other mental health facilities.

Germany's Social Code is comprised of 12 books (Campos, 2016:5). The First Book of the Code of Social Law states that people who are mentally disabled have a social right to the assistance they require (Wilken & Breucker, 2000:11) and health promotion in accord with the structural reform contained in the Health Care Act, 1989 (Federal Republic of Germany, 2012) became a legal requirement of health insurance policies (Gaebel & Zielasek, 2015:14). The mentally ill are not catered for as a federal act on its own but are catered for under other acts such as the German Penal Code against Dangerous Habitual Offenders" Act, 1933 and other policy provisions in Germany.

An inquiry into mental health care in the form of a report titled “Psychiatrie-Enquete” - the German Report on the State of Psychiatry in 1975, pointed to the appalling state of German psychiatric care, citing inhumane treatment and miserable living conditions and understaffing. Thus, there was a recommendation for a change in the direction of deinstitutionalisation from large hospitals to home and community care services (Coldefy, 2012:1; Finzen, 2015). Well-funded reform (11% of the health budget) took place in the latter half of the 20th century with regard to the practice of deinstitutionalisation. Many people with enduring mental illnesses were discharged from hospitals, and community mental health services were simultaneously introduced (Salize et al., 2007:92). This led to a decrease in the number of dedicated psychiatric hospitals and a consequent decrease in the number of psychiatric beds, as well as the end of “asylums” (Konrad & Opitz-Welke, 2014:517; Leping, Steinert, Gebhardt & Röttgers, 2004:94). The decrease, however, did not lead to a total abolishment of psychiatric hospitals as it was restructured towards regionalised (catchment area) acute care in line with the general hospitals (Coldefy, 2012:4). Other changes included integrating the existing psychiatric units into general hospitals, introducing day hospitals, increasing office-based psychiatrists, introducing hospital-based outpatient amenities, and implementing social psychiatric services (Salize et al., 2007:93).

Psychiatric beds decreased from 117 000 in 1970 (in West Germany alone), to 54 088 beds in 2007, of which 40% were in general hospitals and 8% in the private sector. The number of community-based centres for outpatient care services in mental health in 2007 was 523, whilst there were 586 other outpatient services with a total of 63 427 number of places in non-hospital accommodation (Coldefy, 2012:4). Germany in 2011, had 270 psychiatric hospitals and provided 15,3 psychiatrists per 100 000 population (Campos, 2016:14). These figures do not include forensic patients.

Mental health service delivery is meted out in extensive disproportions in urban and rural areas. Because the health system is structured at state (Länder) level, there are many regional differences in mental health provision, although hospital bed capacity is fixed by the state. Large gaps are found in the varying sectors that

offer mental health services with regard to hospital and outpatient care. Many general and psychiatric hospitals oversee outpatients who suffer with serious disorders and who are attended to by office-based psychiatrists, whilst the second type of outpatient care addresses those with chronic mental illness who also require long-term rehabilitative care. The psychiatrist who incorporates the services of social workers and or psychiatric nurses provides for this service (Coldefy, 2012:5).

There is no countrywide mental health law in Germany. According to Zielasek and Gaebel (2015:14), the 16 German states are responsible for planning and regulating mental health of mandatory admissions, and the German Civil Code together cover those mentally ill persons who are unable to care for themselves. They do this by adopting state-level health legislation. The national government avails a rudimentary legal framework by passing general health care legislation. Mental health care services are managed across many sectors and as a result are characterised by substantial regional inconsistencies (Salize et al., 2007:93).

Federal and state laws apply in forensic psychiatry. This is supported by the World Health Organization (2014) which reports that Germany does not have a Mental Health Policy or reported mental health legislation, but that their law is fully aligned to human rights covenants.

Detention of the mentally ill who are found guilty of criminal acts and require admission to forensic psychiatric care is covered under the Federal Penal Code (Strafgesetzbuch), and the Federal Civil Code (Bürgerliches Gesetzbuch) legislates detention to avoid self-harm resulting from a mental disorder (Zielasek & Gaebel, 2015:14).

3.4.2.4 The Federal Prison Act of 1976

On 1 January 1977, the Prison Act of 16 March 1976, a federal law, was entered into force. It applies only to adults. The Federal Constitutional Court decided in 2006 that legislation for juvenile corrections must be developed and enforced in

2007. The process of developing prison codes for young detainees had taken prominence in the German states after this decision (Lehman, 2012:132).

According to the Berlin Senate Department for Justice and Consumer Protection (2015:5), the Federal Prison Act of 1976, with its amendments, is possibly one of the most advanced and progressive prison acts in the world. Resocialisation and rehabilitation (as in Section 9) are the cornerstones of Germany's penal system and constitute the aims of the Federal Prison Act of 1976 (Subramanian & Shames, 2013:7). In accordance with the Act, the detainee is given an opportunity to have a say in his/her sentence plan, thereby crafting a path towards his/her own rehabilitation (Section 4). An interesting concept of open prisons (Section 147) was introduced, and an advisory board (Sections 163-164), which would listen to the complaints and requests of detainees, was established at each prison and medical care for detainees became more structured (Berlin Senate Department for Justice and Consumer Protection, 2015:5).

Section 56 of the general rules which is in line with the human rights attitude, indicates that care should be taken of the physical and mental health of detaines. This has implications for the management of detention facilities to support all steps being taken for the implementation and the protection of health and hygiene, and that includes not resisting medical examination upon admission as prescribed in Section 5 of the Federal Prison Act of 1976 (Federal Republic of Germany, 2013:14). In Germany, general health insurance is deferred once a person is imprisoned and this means that the payment for treatment costs of detainees would be paid for by the detentionfacilities' budget (Lehmann, 2012:132).

Section 136 of the Federal Prison Act of 1976 indicates that detention in a psychiatric hospital will be managed by way of considering the medical conditions and providing the needed "supervision, care and nursing" in order to ensure that necessary intervention should be able to, as far as possible, cure or improve the detainee's health so that he does not pose a danger to him/herself or the public (Federal Republic of Germany, 2013:31).

Importantly, Section 138 provides for the detention of alcoholics or drug addicts in a detoxification centre or a psychiatric hospital for those detainees considered dangerous. The aim thereof, is to remedy the individual's addiction and also to address the cause of this addiction (Federal Republic of Germany, 2013:31). These treatment orders are for an indefinite period, but the maximum period for this seems to vary for different authors. Dessecker (2009) indicated that this period seems to very rarely exceed three years, whilst Konrad and Lau (2010:237) indicated that detention is for a maximum period of two years. There are, however, judicial processes every year to review whether additional commitment is necessary. All other mentally disordered detainees can be imprisoned unless the court imposes milder sanctions, like a fine. This is dependent on certain conditions which include that they must not be considered as dangerous, they must have been considered competent to stand trial, and they must have not been declared as "not criminally responsible" (Konrad & Lau, 2010:237).

Reform of the Parole System and Amendment of the Provisions for Subsequent Preventive Detention Act of 2007 aimed to improve public safety and deliver added rigorous monitoring of criminals released from the CJS or from forensic psychiatric custody. With this reform, parolees (former forensic patients) were issued a "therapy order" which obliged the parolee to submit him/herself either to psychotherapeutic, psychiatric, or socio-therapeutic care and treatment. These forensic outpatient centres function to treat and monitor the patient at the same time. As part of the parole conditions, the parolee is compelled to report in-person at predetermined times or schedule at a medical doctor or psychotherapist's office, and non-compliance is regarded as a violation (Konrad & Lau, 2010:238). An uncharacteristic legal regulation with treatment at a "Forensic Outpatient Center" is an information disclosure obligation. Information revealed by the therapists in confidential discussions during therapy sessions is not regarded as a breach of confidentiality between detainee and therapists. This is only the case if such a disclosure is essential to help avert a criminal detainee from recidivating (Konrad & Lau, 2010:239). Although the Federal Republic of Germany provided the legal framework for this, the different states must still work to determine their structure in terms of content (Konrad & Lau, 2010:238).

In addition to the Federal Prison Act of 1976, the Juvenile Justice Act of 2003 makes provision for “children (under 14 years), juveniles (14-17) and young adults (18-20)” and advocates the right of the child to receive the necessary support and access to education. Child and youth organisations are mandated by these legislations to protect and allow for the personal development of children, juveniles, and young adults. Juvenile cases are heard in a juvenile court. The Juvenile Justice Act of 2003 is applicable for all persons who commit an offence between their 14th and 21st birthday, and does not sanction juveniles to hard-core punishment. The CJS aims to provide education programmes to the juvenile or the young detainee. It provides for explicit sanctions such as that of attending education as a disciplinary measure but also allows for the youth to be imprisoned with the likelihood of being suspended or being placed on probation (Jehle, 2005:35).

Since the minimum age of criminal responsibility is 14 years, persons under this age group cannot be placed on trial. Juveniles are only criminally responsible if there is proof that the juvenile was sufficiently able to understand the wrongfulness of his/her action and behaved accordingly (Pruin, 2011:3). In the cases of young adults it will be decided by the relevant authority if the punishment meted out will be in line with the Juvenile Justice Act of 2003, or if that of the Criminal Code is applicable in each individual case. If diversion/discharge is not possible, then the court enforces a “formal sanction” on the principle of “minimum intervention”. The last resort is detention in a juvenile detention facility (Pruin, 2011:6). There is a widespread recognition that juveniles are less mentally blameworthy for their crimes, more receptive to rehabilitation, and more vulnerable to abuse in detention (Matthews, Schiraldi & Chester, 2018:11).

3.5 NIGERIA

3.5.1 Current developments in Nigeria – Post 1999

Islamic criminal law, also called the Sharia law, was abolished in 1960 when Nigeria gained its independence and crimes were still being prosecuted according to the 1959 Penal Code. It was reintroduced in 1999, in compliance with the

Constitution of the Federal Republic of Nigerian (Federal Republic of Nigeria, 1999; Weimann, 2010:90). Initially, the different states of Northern Nigeria conformed to their own penal codes, however, a Federal Sharia Penal Code was developed and legislated but was not implemented in all states. Likewise, the Sharia Criminal Procedure codes were developed and adopted yet not implemented in all Islamic states (Weimann, 2010:94). The Sharia penal law was stringent and had human rights activists in a furor for allowing death by stoning for crimes like illicit sexual intercourse (Terman & Fijabi, 2010:37). For purposes of this study, the Sharia legislations will not be discussed in detail.

Changes took place in 1999 when military rule was done away with. One such change was that of the abolishment of the tribunals which was mainly made up of police and military personnel. Tribunals were established to deal with economic and political violations, but often went beyond this and arraigned offences under the Penal Code. They meted out harsh punishments and could even order the death penalty (Coldham, 2000:228-229).

Several reform programmes were introduced by the government in mid-2001 under civilian rule to review prison law, revive the prison system, and to tackle challenges in meeting the basic human rights of detainees. Such challenges included insufficient treatment for medical problems, and issues like overcrowding, poor living conditions, lack of skills training, and poor infrastructural issues, which hindered rehabilitation efforts (Opafunso & Adepoju, 2016:2). Part of the reforms included getting rid of the perceived notion that the Nigerian prison system is a passive element in the criminal justice administration. In order to do this, numerous task teams and boards on prison reform with diverse mandates and frames of reference were established from 2000-2007 (Obioha, 2011:100).

The National Working Group on Prison Reform and Decongestion concluded in 2005, that 65% of detainees were awaiting trial, and this contributed to the overcrowding of detention facilities which in turn contributed to the “harsh and life threatening” detention conditions (Adegbami & Uche, 2015:29). An Inter-Ministerial Summit on the State of Remand Inmates in Nigeria's Prisoners, as well as the Presidential Committee on Prison Reform and Rehabilitation, were

established in response to the 2005 report, and recommended that the Federal Government address the shortage of defence counsel that was exacerbating the large numbers of awaiting trial detainees (Opafunso & Adepoju, 2016:2). So serious was reform taken, that the commission established the "Presidential Commission on the Reform of the Administration of Justice" (PCRAJ) on 16 March 2006. Its purpose was to appraise the management of justice in Nigeria and investigate the concern about the detention of non-violent individuals who were alleged to have committed minor offences (Opafunso & Adepoju, 2016:2).

The Nigerian Correctional Services (NCS) falls under the Ministry of Internal Affairs and its headquarters is in Abuja. The Controller-General is the accounting officer of the NCS and controls six Deputy Controller-Generals. The welfare directorate is responsible for the wellbeing and health of the detainees and that of the staff of the NCS (Olalade, 2004:38). There are also 36 state prison headquarters with eight zonal headquarters in some of the designated states and training institutions. The NCS has 234 detention facilities with an average detainee population of about 71 522 on 19 March 2018 (Walmsley, 2018a). The NCS accommodates about 2000 physically and mentally disabled (Olalade, 2004:38). This is about 5% of the population of detainees.

Various authors, such as Chukwuemeka (2010:115) and Obioha (2011:104), agree that the reform process in Nigeria did not take place as desired. They indicate that though these efforts were made, Nigeria was still plagued by overcrowding, in some instances between 100% - 241% as at 2008, and that 33,3% of facilities lacked any medical facility such as a hospital or clinic. The Nigerian Prison Reform (NPS) was part of the process to reform the Nigerian CJS, in line with worldwide developments, to that of humane treatment, with an emphasis on the welfare of detainees and their rehabilitation. This therefore also has implications for the mentally ill detainees in Nigerian detention facilities.

3.5.2 Legislations Governing the Management of Mentally Ill Detainees

In line with the United Nations Convention on the Rights of the Child (UNCRC), the African (Banjul) Charter on Human and People's Rights, and the African

Charter on the Rights and Welfare of the Child (1990) (ACRWC), Nigeria developed The Children and Young Persons Act of 1943 (CYPA), which dealt with the treatment of young detainees and was signed into law by the British. Since then, it has been amended a few times and enacted in the Northern Region in 1958 and instituted as the Children and Young Persons' Law (CYPL) Cap 21 of the Laws of Northern Nigeria 1963. Children are mainly considered immature and blameless and therefore may lack an understanding of the impact their negative/positive actions have on others. It prescribes the wellbeing of the young, the management of young detainees, and the establishment of juvenile courts (Iguh, 2011:101). The CYPL defines a child as a person under the age of 14, while a young person refers to a person who has reached the age of 14 years but is still under the age of 17 years (Obidimma & Obidimma, 2012:84).

The Child's Rights Act of 2003 (CRA) brought together all Nigeria's acts concerning the child under one umbrella act. The CRA guarantees on paper the provision of 'special protection measures' or special needs of disabled children within available facilities or resources. Debates in Nigeria ensued on the wording of "subject to available resources" as it implies that provision of services is not necessary if the resources are not available. It did not oblige the government or the service providers to provide the resources. The CRA defines a child as a person under the age of 18 years (Ajanwachuku & Faga, 2018:57). This is in contradiction to Nigeria's Criminal Procedure Act of 1990 which defines a child as someone who is below 17 years (Federal Republic of Nigeria, 1990b).

Section 209 (1) and (2) of the CRA provides for children's cases to be diverted away from judicial proceedings of a formal trial. Other manners of settling the case include supervision, restitution, and compensation of victims (Arowolo, 2018:88). The CRA has only been adopted in 25 of the 36 states of the Federation, whilst the other states have not done so because of culture and religion.

The CRA stipulates that incarceration can be ordered, but only as an action of last resort, even when the child is tried and found guilty. Furthermore, a child will not be exposed to corporal punishment nor subjected to the death penalty

(Iguh, 2011:104). The CRA does not specify the age of a child's criminal liability (Arowolo, 2018:88).

3.5.2.1 Criminal Code Act of 1990 and the Penal Code (Northern States) Federal Provisions Act of 1960

Nigeria keeps a compilation of federal laws named the Laws of the Federation of Nigeria. It is an alphabetical index of the country's Acts and subsidiary legislation made from 1990 and arranged in chapters (CAPs) (e.g. the Criminal Code Act is found in Chapter 77). Each state of the 36 states, as well as the Federal Capital Territory, Abuja, has its own laws.

The Criminal Code is accompanied by the Criminal Procedure Act (CPA), Cap 80, Laws of the Federation of Nigeria, 1990. This law makes provision in Section 22 that a mentally ill person may be detained in an asylum for observation (Federal Republic of Nigeria, 1916:11). The Penal Code is accompanied by the Criminal Procedure Code (CPC), Cap 81, Laws of the Federation, 1990. This law makes provision for the death penalty (Federal Republic of Nigeria, 1916:10). This law is under much scrutiny from all human rights activists across the world (United States Department of State, 2017b:14).

Nigerian law regarding insanity, is, like many other countries, based on the M'Naghten Rules which assume that every person is sane until the opposite is proven, as indicated in Section 27 of the Criminal Code Act of 1990 (CCA), and Section 51 of the Penal Code (Abiama, 2015:60; Idem, 2018:14). The plea of insanity in Nigerian law, is laid down in Section 28 of the CCA, which indicates that an individual is not criminally responsible for performing an act or oversight if he/she was diagnosed with a mental illness or a "natural mental infirmity" when the act was committed. This will hold true provided that the mental illness or a "natural mental infirmity" decreased his/her ability to understand what was being done, decreased his/her capability to control his/her actions, or the capacity to recognise the act is wrong. The second arm of Section 28 talks of the person being found responsible for his/her actions despite being "delusional" (Federal

Republic of Nigeria:1990a). According to Idem (2018:15), the accused can still raise some defence under the second arm of Section 28, provided he/she has proof that he/she had some infirmity of the mind or delusion about some specific matter or matters. This is illustrated in the case of *Edoho vs. State* as cited in Idem (2018:14). State, the appellant in this case was found guilty of stabbing Mr Edoho to death. However, his defence was that he was under the influence of witchcraft and was therefore temporarily insane and was not able to control himself. The appellant appealed his guilty verdict, but the guilty verdict was upheld based on Section 27 which states that "every person is presumed to be of sound mind, and to have been of sound mind at any time which comes in question, until the contrary is proved". The burden of proof thus lay with the appellant, but he failed to convince the court (Idem, 2018:14).

Abiama (2015:60) outlines the kinds of mental conditions which could have an impact on a person's blameworthiness for an offence. The first, may be due to a mental illness where the act is committed involuntarily (referred to as "automatism"). The second, is a conscious and willing decision to commit the act but he/she does not understand what he/she is doing because of his/her mental illness. The third, brings in the element of not being aware that the act is wrong. The fourth instance, is where the person knows what he/she is doing (knows that the act is wrong) but owing to the mental illness, is incapable of controlling his/her actions. The last, being the case where the individual knows what is being done, is aware that the act is wrong, but because of his/her mental "delusional" state he/she may be of the view that his/her action is right.

The diminished responsibility due to intoxication (narcotics or drugs) is outlined in Section 29(2) of the CCA and states that such defence can only be used if the state of intoxication was caused by another without the accused's knowledge and it rendered the accused temporarily insane or otherwise (Federal Republic of Nigeria:1990a). In this case, the onus to prove diminished responsibility is on the accused.

Section 30 of the CCA stipulates that the age of criminal responsibility in Nigeria is seven years which means no child below seven years can be prosecuted for

breaking the law. It also states that a child of 12 years is not criminally liable unless it is proven otherwise. Added to this, is the indication that a male child under the age of 12 years is presumed to be incompetent of having "carnal knowledge" (Arowolo, 2018:93).

Idem (2018:15-18) also highlights the different terminology used in the CPA and the Penal Code. In the CPA there is reference to "mental disease" or "natural mental infirmity" or "delusions", whilst the Penal Code talks of "a person of unsound mind" (Idem, 2018:18).

3.5.2.2 Criminal Procedure Act of 1990 (Southern Nigeria) and the Criminal Procedure Code of 1960

The insanity defence is deliberated upon at the hearing of very serious offences, mostly murder. The court can at any stage of the trial request that an investigation is carried out at an asylum or at a psychiatric hospital. The trial is discontinued, and the accused is ordered to be placed under observation for a maximum period of one month.

The medical officer at the asylum or psychiatric hospital must submit a report of his/her opinion to the court. Should the medical officer require extra time to observe the state of mind of the accused, he/she can request for an extension of the observation up to a period of two months as indicated in Section 223(4) of the CPA (Federal Republic of Nigeria:1990b). The case will resume as soon as the accused is fit to stand trial and if the certification from the medical doctor indicates that he/she is of sound mind and fit to stand trial as indicated in Section 224(1) of the CPA (Federal Republic of Nigeria, 1990b). If the accused person is found to be of "unsound mind and incapable of making his defence" it will not be required of him/her to attend the proceedings. The case will start anew. The court will decide on the matter based on the substantiation of the medical officer and the observation of the accused by the court, but the court is not obliged to accept the expert opinion of the medical doctor. Idem (2018:19) argues that it is vital that before imprisoning an accused, the certification of being declared mentally ill must be decided upon by both a medical expert and not solely by a judge.

Part 2 of the Criminal Procedure Act of 1990 (CPA) outlines the rights of the arrested person and includes in Section 4 that a person who is arrested will not be unnecessarily handcuffed, tied up, or restrained unless it is an order from the court/judiciary. The person may be handcuffed, tied up, or restrained if it is necessary to prevent escape, if the person is violent, or if it is deemed necessary for the safety of the person. It also stipulates in Section 9 that the arrested must be informed as soon as possible without delay of the charge against him/her (Federal Republic of Nigeria:1990b).

Procedures relating to the mentally ill are outlined in Part 25 of the CPA where the mentally ill are categorised under persons of unsound mind. The CPA also refers to an asylum as a locale for detaining/accommodating mentally ill individuals, and could mean “a lunatic asylum, a mental or other hospital, a prison and any other suitable place of safe custody for medical observation” (Federal Republic of Nigeria:1990b).

Section 230 of the CPA authorises the Governor to use his/her discretion to order detainees, who are found not guilty because of their “insanity”, to be sent to an “asylum” and not a prison. Ogunlesi and Ogunwale (2018:35) are unwavering in their belief that Nigerian governors interpret an asylum to be a prison, and therefore still order the mentally ill to be treated in corrections and not in external facilities. Detainees with severe mental disorders are sometimes transferred to psychiatric hospitals for hospital-treatment through an order by the courts. In some instances, a transfer from the corrections hospital to a psychiatric hospital is authorised through an administrative order which is supported by a certificate issued by a corrections medical officer (Ogunlesi & Ogunwale (2018:36).

The CPA makes it clear that the person is not confined to an asylum for a fixed term. When the mentally ill detainee is certified by a medical doctor to have recovered from his mental illness, his/her release from safe custody lies arbitrarily with the Governor as indicated in Section 228 of the CPA (Abiama, 2015:65).

3.5.2.3 Sharia Penal Law (applicable to the Northern States practising Islam)

Sharia Penal Law consists of the Sharia Penal Code Law 1999 and the Sharia Criminal Procedure Code Law No. 18, 2000. The Sharia Penal Code Law classifies the various offences in accordance with the applicable punishments, whilst the Sharia Criminal Procedure Code Law No. 18, 2000 makes provision for procedural rules that must be used by the Sharia courts in their prosecution and implementation of the Sharia Penal Code Law (Oraegbunam, 2011:192).

The concept of guilty intention is completely recognised in Islamic law, which basically means that there is no criminal act if there is no intention to commit crime. According to Shari'ah, "lunatics" have diminished judgment and self-control and therefore cannot be held accountable for their actions (Tzeferakos & Douzenis, 2017:3).

Islamic law places insanity into three categories. These are: absolute or continuous insanity; intermittent insanity; and partial insanity. In order for an accused to be found "not guilty by reason of insanity" it must be proved that the detainee suffered with a mental disorder which was active at the time he/she committed the act (Tzeferakos & Douzenis, 2017:3).

With regard to criminal responsibility, Islamic law recognises two additional categories which can render the defendant "not guilty by reason of insanity". These are: if the person is attacked by "Dahish" (sudden confusion or perplexity); and the "Atah" (mental retardation or dementia) (Tzeferakos & Douzenis, 2017:3). It must be noted though, that only the assessments and the opinions of Muslim psychiatrists are accepted in a Muslim Trial. Shari'ah law does not base the need for involuntary hospitalisation on the dangerousness of the detainee but on the patient's need for therapy, and this would include those patients that have substance use disorders (Tzeferakos & Douzenis, 2017:3-4).

3.5.2.4 National Health Act 8 of 2014

In Nigeria, health care is provided by two sectors, namely, the public health care and private health care sectors, and is offered at primary, secondary, and tertiary levels. Non-governmental organisations (NGOs) also involve themselves in health provisioning. Such examples are the Mental Health Awareness Programme (MHAP) in South East Nigeria, established in 1990 aimed at supporting homeless people with severe mental illness (Eaton, Nwefoh, Okafor, Onyeonoro, Nwaubani & Henderson, 2017:2).

Specialist tertiary services are the obligation and mandate of Federal Government and secondary health services are managed by each respective state. Primary health care is offered at the local government level. In Nigeria, the local government levels are compared to a health district, which is made up of primary care clinics and controlled by health wards (Eaton et al., 2017:2).

There are insufficient mental health professionals in developing countries, which includes Nigeria. This results in poor service being rendered to the large Nigerian population. Nigeria has a population of approximately 197 million as at April 2019 (World Bank, 2019). There is one psychiatrist that services 1 million Nigerians and four psychiatric nurses per 100,000 people. According to Ude (2015:1), approximately five psychiatric hospitals exist in Nigeria, and all of them were not operating properly. However, the situation changed in 2017 where there were eight Federal Neuro Psychiatric Hospitals in Nigeria (Eaton et al., 2017:1). Mental health is provided predominantly in large government psychiatric hospitals. There has however, been a turn to servicing mental health in the community, with a few clinics being established in the “locations”. According to Eaton et al (2017:1), there has been an improvement in the availability of care, but these services are not fully utilised due to the associated stigma and poor knowledge of the Nigerian population on the treatment of mental illness.

The National Health Act 8 of 2014 provides a regulatory framework for health provisioning and subsequently, as dictated by the Act, a National Health Policy was enacted in 2016. The National Health Act 8 of 2014 does not explicitly

mention mental health (Federal Republic of Nigeria, 2014:139-172). The National Health Policy 2016 aims to attain the well-being of people with disabilities in order for them to ultimately attain economically productive lives. As at December 2011, there were 34173 health facilities in Nigeria, and 88% of these are primary health care facilities (Federal Ministry of Health, 2016:23).

As discussed in Chapter 2, British colonisers who were concerned with the challenges of inadequate treatment and mentally ill persons wandering the streets, enacted the Nigerian Lunacy Act of 1958, which still acts as the main framework for mental health issues in Nigeria. The colonial Lunacy Act of 1958 was custodial in nature. Since its operationalisation, it was found that the definition of mentally ill persons as “lunatics” is discriminatory and derogatory, and still does not fully address treatment (Ude, 2015:2). This resulted in a bill being developed in 2003, with the aim of repealing the Lunacy Act of 1958, and replacing it with a new Mental Health Act 8 of 2004, which focussed on the human rights of persons suffering with mental illness (Westbrook, 2011:407-409). The Mental Health Act 8 of 2004 redefined the word “lunatics” and incorporated more acceptable international principles of mental health. Further to this, it would have included procedural safeguards by firstly, including temporary admission for observation, emergency application admission, and admission for treatment; and secondly, by prescribing the time to be spent in detention as per each type of admission. The new Bill reviewed the role played by magistrates in the admission decision. It also recognised that people must only be detained in institutions if detention was a requirement for treatment. The Bill set out minimum standards for facilities that would detain the mentally ill (Westbrook, 2011:407-409).

This Bill had the support of human rights, health organisations, and other health service providers, but not the support of the National Assembly. It was withdrawn in April 2009 (Westbrook, 2011:399).

3.5.2.5 Nigerian Prison Act 9 of 1972

The administration and control of the Nigeria Prison Service is established as per Section 2 of The Nigeria Prison Act 9 of 1972, Chapter 366 of the Laws of the

Federation of Nigeria, 1990 (NPA). The Nigerian detainee population consisted of civilian detainees, prisoners-of-war, debtors, and state convicts. Persons under remand also fell within the jurisdiction of the NPA. Administratively, Nigerian detention facilities are classified into five categories, namely, the "convicted prisoners", the "divisional prisoners", the "provincial prisoners", "lock-ups", and "prison camps" (Onyekachi, 2016:1).

Section 7 of the Prison Act 9 of 1972, addresses the "insanity of prisoners". Subsection 1 stipulates that the superintendent of a prison must report to the Minister of Interior if he/she suspects that a convicted detainee or a detainee sentenced to death is of "unsound mind". The Minister is tasked by the Act to appoint a minimum of two medical practitioners to investigate this. The two medical officers must provide a written report, and if applicable, provide a certificate indicating that the detainee is of unsound mind. This must be issued to the Minister via the Controller-General's office. The Minister can also issue a directive for the removal of the detainee to a detention facility equipped with a health facility, or to an external hospital, before the Minister receives the written report or the certificate (Federal Republic of Nigeria, 1972).

Subsection 3 of the Prison Act 9 of 1972 indicates that an detainee sentenced to death will have his/her execution suspended while waiting for the written report of the medical practitioners. If the detainee is certified to be of unsound mind, then he/she is placed in an appropriate hospital for the mentally ill and has to abide by the mental health laws.

Any other detainee certified to be of unsound mind shall be ordered by the Minister to be sent to a mental hospital. Mental hospitals fall under the authority of the mental health laws and is to be detained there until he/she recovers enough to be certified to be of sound mind, or until the sentence expiry date. All detainees certified to be of sound mind will continue to serve their sentences in corrections (Federal Republic of Nigeria, 1972).

The NPA dictated the establishment of the Nigerian Prison Services. Legislators began to realise that the NPA was not keeping up with modern corrections

management principles and thereby placed the NPA on review (Onyekachi, 2016:6). Upon analysing the Nigeria Prison Act of 1972, amendments were recommended by the 6th National assembly. Reasons given for amending the NPA were that it was archaic; it did not focus on rehabilitation but on the punitive and retributive aspects of imprisonment; and was silent on the reintegration of detainees. Most importantly, it did not integrate the 1999 country's reforms into corrections management. Onyekachi (2016:6) remarks that the Prison Act of 1972 simply mentions the welfare of detainees, and the aim to be integration back into society. A corrections detention facility also accommodates "lunatics" and convicts declared condemned to asylums. Examples of such facilities include Enugu, Jos, Warri, and Port Harcourt detention facilities, but no section of the Act fully addresses the important issue of the management of mentally ill and physically disabled detainees. Although a substantial amount of time was spent on the review of the NPA, these amendments were not brought about (Onyekachi, 2016:6).

The Country Reports on Human Rights Practices for 2017, found that mental health care services were almost non-existent in correctional facilities. All detainees afflicted by some form of disability were not provided for in terms of specialised services or separate accommodation (United States Department of State, 2017c:39). This is in contradiction of the Nelson Mandela Rule No 12 (United Nations, 2016a:6). However, there are some instances in Nigeria where corrections officials took the initiative of sourcing private donations to separate mentally ill detainees from the general detainee population and to provide separate mental health detention centres (United States Department of State, 2017c:39).

3.6 UNITED STATES OF AMERICA (USA)

3.6.1 Current Developments in the USA - 20th century

The United States (US) correctional system placed emphasis on rehabilitation prior to the 1970s (Gavin, 2011:251). This was brought about by the Prison Act of 1898 and it emphasised that the main aim of imprisonment was preventing

offending and re-offending as well as rehabilitation (Karpinski, 2018). The Prevention of Crime Act of 1908 saw the introduction of the “Borstal System” which believed in physical work, technical and educational training, as well as religious care for the youth. It also emphasised once again the earning of credits towards their release (Karpinski, 2018). New models of detention facilities were being built and the concept of open prisons sprang up in the 1930s (Karpinski, 2018). Lux (2012:10) refers to the period 1945-1960 as a period of “Juvenile Delinquency, Progressive Reforms and the Beginning of the End of Rehabilitation”. The focus on the rehabilitation of detainees in the USA started back when the American correctional system was formalised in the 1900s (Lux, 2012:11). Institutions such as the American Prison Association, the Correctional Educational Association, the Kennedy campaign amongst other Presidential campaigns, looked into the issue of riots, poor detention conditions, poor staff salaries, education and training opportunities, political influence in staff appointments and in detention matters as a whole, issues of homosexuality, the issue of the cottage system for females (size of cottages were too small), media advocacy in corrections matters, prison industries, the effectiveness of rehabilitation programmes, as well as the provision of psychiatric care in correctional facilities, amongst others (Lux, 2012:12-29). Detainees in need of psychiatric care were to be transferred to mental institutions. However, mental institutions were so congested that an exchange system was implemented where psychiatric hospitals would only accept mentally ill detainees if the corrections authorities agreed to receive those mentally ill persons who were not responding to treatment (Lux, 2012:30).

The Criminal Justice Act of 1948 eradicated hard labour and flogging and provided a systematic approach to imprisonment. Further to this, it reinforced “borstal institutions” (Karpinski, 2018). In 1965, the Correctional Rehabilitation Study Act of 1965 and The Law Enforcement Assistance Act of 1965 were passed and brought with them the change in terminology from “guard” to “correctional officer”.

According to Phelps (2011:33), the turning point in the US penal history was the 1970s.

Legislators started to realise that rehabilitation no longer worked and there was a need for a more “punitive” approach towards incarceration. With the increase in drug use, and an increase in crime and youth rebellion, the focus shifted to deterrence and incapacitation of the detainee in the hope that longer sentences would deter crime (Hatcher et al., 2009:9; Karpinski, 2018; Lux, 2012:10). Other radical and social events, namely, the civil rights protests and anti-war protests also called for penal reform. A case that is worth mentioning, in particular, is the murder of George Jackson of the Black Panther Party, who was imprisoned at the age of 18 for a minor crime. He ultimately spent more than 10 years in incarceration due to the application of indeterminate sentencing laws for protesting against detention conditions. His “murder” led to the Attica riot (Campbell & Schoenfeld, 2013:1390). The public called for the CJS to take responsibility for the dismal failure of the system to rehabilitate detainees and this led to the federal and state governments remodeling sentencing guidelines (Lux, 2012 95-117).

According to Karpinski (2018), incarceration rates increased by 500% in the period from 1970 – 1999, thus resulting in overcrowding.

In a landmark case of *Estelle v Gamble* [(Estelle v. Gamble 1976 (429) US (97)] medical care to detainees was made a constitutional right as indicated in its Amendment Eight which reads “nor cruel and unusual punishments inflicted”. Although this amendment was in response to the death penalty, it suggests that any form of ignoring the detainee’s serious medical needs constituted a grave irresponsibility of adding to the pain and suffering (United States of America, 1791:593; Lines, 2008:20). Arguments based on this, included the fact that detainees were vulnerable and dependent on the correctional system to provide for their medical care (Gavin, 2011:253-254). What must be noted though, is that the Constitution, which was signed in 1787, does not make specific reference to mental health. The amendments to the Constitution came in the form of The Bill of Rights (Amendments 1 to 10), which was in 1789, and ratified on 15 December 1791 (United States of America, 1791:5930).

Campbell and Schoenfeld (2013:1390) state that detention facilities in 35 jurisdictions in the USA had been declared unconstitutional in 1980 due to the

non-adherence to proper health care, overcrowding, and cases of abuse and cruel treatment. It is because of the requirements outlined in the Eighth Amendment regarding the extension of national protection of detainees' rights, that the national courts and civil rights solicitors became prominent participants in the state penal domain.

The Mental Health Services Act of 1980 (a piece of federal mental health legislation) and the Mental Health and Mental Retardation Facilities Act of 1980 had repercussions on mental health in the correctional setting. The notion of the de-institutionalising of the mentally ill, and the provision of mental health services within the community was emphasised. Challenges were experienced in the implementation of these Acts when the Omnibus Budget Reconciliation Act of 1981 saw a decrease in national funding and an allocation of block funding to the states. This increased "homelessness" and escalating prison and jail populations. State mental hospitals closed and there was insufficient community support. Another spin-off from this, was the increase in suicide rates in jails, which varied from 10 to 14 per 100,000, to 57.7, and then to 108 per 100,000 in jails (Lux, 2012:83-88).

The enactment of the Violent Crime Control and Law Enforcement Act of 1994 introduced reforms that resulted in states receiving substantial grants to expand facilities ($10 billion). Some of these implemented reforms were the truth-in-sentencing acts which aimed to put an end to parole so that criminals serve the full period to which they have been sentenced. Others were the "three-strikes and you're out" philosophy, more stringent laws that imprisoned repeat offenders, thus resulting in high incarceration rates, and legal responsibility for juveniles. Further to this, mental health facilities were deinstitutionalised, adding to the already overburdened correctional facilities (Gavin, 2011:253-254, Karpinski, 2018). With these reforms, it was believed that mentally ill persons were arrested for minor crimes, and law enforcement officers might be more liable to arrest them if no suitable mental health amenities were accessible. This is referred to as "mercy booking" (Hatcher et al., 2009:9). Essentially, the correctional system had turned into the new asylum, albeit one that failed to address the challenges of limited treatment options for its clientele.

Campbell and Schoenfeld (2013:1404) indicate that Congress passed the Prison Litigation Reform Act of 1996. Federal courts still maintained extended sentencing for trivial crimes and racially inconsistent prosecution process implementation. An example of this is that in 2003, the Court endorsed a 25-year-to-life sentence for a Californian who was convicted of stealing three golf clubs worth $1200 and who had two previous convictions.

3.6.2 Legislations Governing the Management of Mentally Ill Detainees

3.6.2.1 The United States Code

The USA keeps a compilation of federal statutory law which is called the United States Code. The US Code is arranged by subjects. Each title in the US Code relates to a subject. For example, title 18 concerns crimes and criminal procedure. The federal government possess its own criminal code, as is the case in every state in the USA and for purposes of this discussion, the federal codes will be used.

The various states of the USA implement criminal capacity differently across its jurisdictions. Some follow the M'Naghten Rules, or the Model Penal Code (MPC), or a combination of the two, or none at all. The M'Naghten Rules call for complete incapacity to comprehend that one's behaviour is wrong. 22 jurisdictions follow the M'Naghten Rules. Six jurisdictions have revoked the insanity defence, whilst 16 follow the MPC. The MPC requires the defendant's mental functioning to be substantively, rather than absolutely, diminished, and that he/she is incapable of "appreciating" the wrongfulness of his/her action. Some jurisdictions such as that of New Hampshire complies with the Durham "product test" rules, which requires that the defendant's mental disorder triggered his/her criminal conduct. According to the Durham Rule there is no requirement that the extent of the mental impairment must be proved (Robinson et al., 2015:41- 42).

The issue of the insanity defence is found in Title 18 - Crimes and Criminal Procedure Chapter 1 "Insanity Defence" and specifically in Section 17(a) titled "Affirmative defense" which state that mentally ill persons could not be held

accountable for their actions if they suffered from a severe mental defect which led to them not understanding that their actions were wrong. Section 17(b) indicates that it is the defendant who must provide convincing evidence of his/her “insanity” (United States of America, 2006:15).

Further to this, Chapter 313 provides for detainees with mental disease or defect. In particular, Section 4241 titled “Determination of mental competency to stand trial or to undergo post-release proceedings” stipulates that the court can order a motion of competency if the court suspects that the detainee is undergoing a mental defect and is incapable of understanding the proceedings. This investigation can be conducted at any stage - once the detainee has started his/her sentence or at any time after commencing his/her probation or even prior to sentencing (United States of America, 2006:831).

Section 4242 covers the determining of insanity when the offence is committed. If the person is found not guilty because he/she was found to be insane at the time of the committing the crime, he/she shall be automatically hospitalised in a suitable facility as per the procedure outlined in Section 4243 until he/she is entitled for release. A hearing on the person's current mental state and threat must be held within 40 days. A psychiatrist’s or a psychological report is mandatory prior to the hearing (United States of America, 2006:832).

Section 4244 has specific reference to the hospitalisation of a mentally ill convicted person. If a person is found guilty of a crime, he/she can file for a motion of insanity. This must be done within 10 days after being found guilty but before sentencing. If the court decides that the defendant is suffering from a mental disorder or defect the person is committed to a suitable facility for care and treatment in lieu of sentencing (United States of America, 2006:835).

Section 4245 makes provision for the constitutional right to a court hearing for an incarcerated federal defendant who objects to being transferred to a psychiatric facility for the purposes of treatment (United States of America, 2006:835).

The Insanity Defense Reform Act of 1984, according to the United States Department of Justice, was the first wide-ranging federal legislation that administered the insanity defence and the management of mentally ill detainees. Prior to 1984, most federal courts were using the American Law Institute's Model Penal Code (MPC). Rule 704 of the Federal Rules of Criminal Procedure regarding expert testimony at the trial, was amended in 1984 to limit the expert witnesses' evidence to representing the detainees' diagnosis of whether he/she had a severe mental disease/defect. The psychiatrist was allowed to provide a clinical analysis, whilst the legal investigator would determine whether the relevant legal test for insanity had been met.

In addition, the important requirements of the Insanity Defense Reform Act of 1984 rejected the defence of diminished capacity and made provision for federal commitment of individuals who became mentally ill after having been found guilty or whilst they were serving a federal imprisonment sentence (United States of America:1984).

3.6.2.2 Mental Health Care Legislation in the USA

The USA, as a developed country, has a vast amount of legislation in respect to the management of the mentally ill, be it in the educational fraternity, in the workplace, among the communities, and parities within the mental health fraternity. Public Health in the USA has been provided by the Public Health Department at national, state, and local level as well as by tribal health departments and private institutions (Gollust & Jacobson, 2006:1733; McClelland, Asplin, Epstein, Kocher, Pilgrim, Pines, Rabin & Rathlev, 2014:8-9; Riley, Bender & Lownik, 2012:238).

For purposes of this discussion, the legislation will be mentioned in chronological order, however only those applicable to mentally ill clients of the CJS will be emphasised.

The Americans with Disabilities Act (ADA) of 1990, as amended in 2008, aimed to eliminate discrimination of any kind towards persons with a mental or physical

disability in the workplace or any other sector of society, as indicated in Section 12101. The Act also institutes requirements for equal opportunities in employment (United States of America, 2008).

The Mental Health Parity and Addiction Equity Act of 2008, called for health insurers and group health plans to avail the same benefits in terms of treatment and services to the mentally ill and substance users as that of other medical care (Mulvaney-Day, Gibbons, Alikhan & Karakus, 2019:5190). Furthermore, The Patient Protection and Affordable Care Act of 2010 made private health insurance possible to mentally ill and those that suffer with substance abuse disorders and which would be subsidised by Medicaid (Corrigan, Druss & Perlick, 2014:56).

Title 31 and Title 32 of The Children's Health Act of 2000 provides for programmes to advance mental health and improve substance abuse amenities for children and adolescents. Section 3107 indicates that youth detainees shall be awarded grants and as a collaborative effort to provide post-hospital care services for youth detainees who have been released from juvenile or CJS facilities, for children and youth that have serious mental disorders or those who are at risk of developing such disorders (United States of America, 2000:79).

3.6.2.3 The Mental Health Reform Act of 2015 and the Mental Health and Safe Communities Act of 2015

Despite the existence of various legislation on mental health being advocated as a health issue in society, not much attention was paid to the implementation of such legislation in the corrections systems. The two Bills introduced to Congress in 2015, namely, The Mental Health Reform Act of 2015 and the Mental Health and Safe Communities Act of 2015 had the same detailed approach to tackling mental health issues. The approach taken was to treat mental health problems as a "public health issue and not only as a public safety matter". These Bills also called for a proactive approach to mentally ill issues and not just as a reaction to post crisis intervention. It did not superficially address educating officials of the criminal justice partners (sheriffs, judges, and correctional officers) on diverting the seriously mentally ill from the CJS, but introduced prevention, early intervention,

and integrated health and behavioural health services (United States of America, 2015a:8-13). The Mental Health and Safe Communities Act of 2015 is an amendment to Section 501(a)(1) of Title I of 8 of the Omnibus Crime Control and Safe Streets Act of 1968. It adds mental health programmes (including corrections programmes) and crisis intervention teams (Section 101) to manage mental health problems (United States of America, 2015b:3). The Act also provides for identifying other funds and to alleviate the strain on the criminal justice and correctional systems. It also sought to assist systems with the required capacity to provide access to mental health and substance abuse treatment services outside institutions. It made provision for funding to the states to facilitate more effective integration of mental health services (United States of America, 2015a:11-12).

In response to policy makers for the funding of community mental health programmes, without slicing the budgets of other health services, The Mental Health and Safe Communities Act of 2015 called on the Federal Government to relook at indeterminate sentencing of mentally ill detainees. The Act makes provision for incarceration of nonviolent mentally ill detainees to a maximum of 10 years. The savings from this could be used to support community services for people with mental illnesses, thus can be seen as a means of reducing the prison and jail populations. The Mental Health and Safe Communities Act of 2015 also emphasised that mentally ill persons attending involuntary treatment, either as an inpatient or as an outpatient, would be considered as “mentally incompetent” and would not be eligible to buy or own a firearm as per the federal gun laws (Trumble & Hatalsky, 2015).

The Act also replaces the terms “mental defective” with “mentally incompetent” and “mental institution” with “psychiatric hospital” (United States of America, 2015b:84).

3.6.2.4 21st Century Cures Act of 2016

The Mental Health and Safe Communities Act of 2015 and mentally ill issues of the CJS introduced by The Mental Health Reform Act of 2015 was subsequently

included into the 21st Century Cures Act of 2016 specifically in Title XIV Section 14001 -14029 “Mental health and safe communities” (United States of America, 2016:1287-1315). In overview, the aims of “Title IX” of the 21st Century Cures Act of 2016 included national support for the various state initiatives, along with building a federal/national infrastructural framework to respond to the larger related challenges of making mental illness an offence (Bard, 2018:395).

Further to this, Section 1409 speaks to “advancing mental health as part of offender re-entry” which provides for adequate housing and appropriate mental health services for detainees who are released from custody or from psychiatric institutions based on a mandatory pre-release assessment (United States of America, 2016:1297).

The major focus of the Act is on avoiding needless confinement of people with mental illness and emphasises improved treatment and services for incarcerated mentally ill detainees and following their release. Section 14003 specifies the possibility of diverting mentally ill detainees from federal prosecution or corrections facilities to federal drug or mental health courts, provided that they were not convicted of a violent crime or a serious drug offence (United States of America, 2016:1289). If such diversions occur, then there would be mandatory evaluation of each case. In cases where the eligible detainees do not comply with program requirements then prosecution or incarceration would be resorted to (United States of America, 2016:1290). An obligation is also established to have processes in place for management of detainees and after care services for the ultimate success of the programme. Such aftercare services must include “relapse prevention, health care, education, vocational training, job placement, housing placement, and child care or other family support services for each programme participant who requires such services” (United States of America, 2016:1290). These programmes and services must however be properly administered and supervised in order to remain within the determined permissible sentence or probation period for the relevant offence but also to allow for the continuation of psychiatric care at the end of the supervised period (United States of America, 2016:1290)

A court may order outpatient treatment to an offender as indicated in Section 14002, in an effort to be accommodated in a less constricting alternative environment not akin to imprisonment or involuntary hospitalisation (United States of America, 2016:1289). A court order for mental treatment, be it outpatient or inpatient treatment, may result in the possibility of dismissing the charges or being given remission by reducing the sentence once the treatment is successfully completed (United States of America, 2016:1290). In addition to this, Section 14012 requires that specially designed in-house treatment programmes be developed and implemented (United States of America, 2016:1297).

Title IX Section 9002 of the 21st Century Cures Act of 2016 makes provision for grants to be given to diversion programmes in jails, whereas Section 2209 outlines the awarding of grants from the federal coffers to states, to units of local government, American Indian tribes, and other sector service providers to plan and implement programs. These programmes must be overseen collectively by agencies within the CJS, a mental health court, juvenile justice agencies, or mental health agencies. These grants are regulated in Section 2209(a)(2) and ought to be used for the purposes of behavioural health requirements and pre-trial risk screening of perpetrators, including mental health evaluation, and criminal history screening. Furthermore, the grants/funding must be used for integrated planning and for human capacity in the CJS, for treatment centres, crisis response, interventions administered to crisis caused by the mentally ill, and by substance users, and for the establishment of mental health courts. These grants also covered areas such as screening of such persons conducting mental health evaluations, as well as provisions of reports at court after the evaluations are completed (United States of America, 2016:1291-1292).

Bard (2018:397) indicates that the 21st Century Cures Act of 2016 emphasises the re-endorsement of the Mentally ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) which in effect was a funding source for a variety of state programmes but it also regulated the manner in which such funds were spent. The MIOTCRA promotes public safety by indicating that grants be utilised for necessitating the availability of mental health services, the right to use mental

health services, as well as access to supplementary treatment services for mentally ill adults or juveniles.

Bard (2018:395) believes that the 21st Century Cures Act of 2016 took a very necessary all-inclusive approach to channel people with mental illness away from the CJS, so that they can access effective treatments and community services. Yet, opponents to the reforms challenge that the Reform Act of 2015 and the Mental Health Act of 2015 and of the Safe Communities Act of 2015 inaccurately assume that unstable mental health is the primary reason for committing violent crimes. It is also argued that court-ordered treatment is a violation of one's rights because it forces treatment without affording the individual a choice (Zarret, 2016:233-235).

3.6.2.5 The Mental Health Services for Students Act of 2019

The intentions of the Mental Health Services for Students Act of 2019 are to advance access to school-based inclusive mental health programmes, services, and support for the mentally ill. It also aims to improve on the Public Health Service Act of 1944 and to increase mental health projects to children. Provision is made in the Act for counselling, not only for the learners who are mentally ill, but also for their family members. Suffice to say, provision is also made for the training of mentally ill learners to improve the wellbeing and the academic performance for children with mental health disorders. Provision is also made to increase the awareness and training of the parents/guardians, and family members of such mentally ill children. This training is even extended to the community. Moreover, the Act legislates the establishment of formalised functioning relationships between health providers and education bodies that support the mental and emotional health of children in the school environment (United States of America, 2019:4).

3.6.2.6 Prison Litigation Reform Act of 1996 (PLRA)

Due to the overcrowding in US detention facilities, detainees began filing lawsuits against corrections citing cruel and degrading detention conditions and a resultant

lack of respect to their human rights. These lawsuits were alarmingly high and were of concern to the Federal Government. Congress, in response, passed a U.S. federal law which was enacted in 1996. The PLRA insisted on detainees following the “exhaustion requirement.” Which basically meant that the detainee must first file a grievance with the head of the facility, and then at state level if the detainee was not happy with the way the grievance was handled. It is only after these processes were followed that the detainee could then file the lawsuit at federal court. Mental illness was no excuse to deviate from the processes (Schlanger, 2015:153-154).

Of concern in the PLRA was that if an detainee filed a lawsuit for mental or emotional injury, which required monetary compensation for damages, he/she must provide physical evidence of this.

3.7 CONCLUSION

Court and release procedures vary for forensic patients in the countries studied. The proper management of mentally ill detainees by the CJS is certainly indicative of the country’s capability to balance public safety and public health. Of utmost importance though is a society’s capability to integrate basic human rights ideologies into penal and health practice. This discussion will further be elaborated on in the next chapter and will include the various human rights instruments.

CHAPTER 4

MENTAL HEALTH CARE AND HUMAN RIGHTS

4.1 INTRODUCTION

According to Araromi (2015:170), a right is an inborn entitlement given to a human and protected by law. There are rights, which are necessary to human existence and cannot be taken away under any circumstance, some rights are curtailed (when the law dictates this), and some are given international acknowledgement in order to promulgate global protection of such rights.

The right to freedom is one of the most precious constitutional rights of a human being, yet this right can be denied to certain individuals or groups for a certain period of time (Coyle & Fair, 2018:13). Once a court sentences or endorses the detention of an accused to imprisonment, the right of freedom of movement for the good order of the administration of the detention facility is restricted. Suffice to say, though, is that they should not be denied their basic essential rights as enshrined in the constitutions of the world and that which is enjoyed by citizens of one's country (Araromi, 2015:171). The Criminal Justice System (CJS) partners are expected to maintain the remainder of detainees' constitutional rights, and infringements on these rights is unjust (Lalla, 2017:15-35).

Many regard mentally ill persons as a segment of the society that is at risk of their human rights being violated (Ventura, 2014:1). This is attributed to their inability to speak up for themselves and have their voices heard, often relying on others to make and take decisions on their behalf. These decisions are often based on the desire to serve the best interest of others rather than what is best for the mentally ill. This supports the view of the World Health Organization (2005:4) that makes reference to their decreased and impaired decision-making capabilities thus exposing themselves to humiliation, being stigmatised, being ostracised in the communities they belong to, and being sidelined to receive proper treatment and care.

The approach to the management of detainees in the countries being studied has changed towards reforming the detainee as opposed to the retributive justice approach. Governments in each of the countries aim to rehabilitate detainees and skill detainees so that they can become better people and ultimately be re-integrated into society. In order for the correction system to achieve this, opportunities found within their naturally endowed rights must be encouraged. This would ultimately talk to rehabilitative efforts as well as treating detainees as humanely as possible within the corrections system (Araromi, 2015:171).

This chapter explores the various International instruments guiding human rights, which are applicable to detainees within the corrections system. In addition, a general discussion will ensue on detainees with mental health care needs. Moreover, country specific information on each country's integration with international instruments is followed by a synopsis on detainees' mental health care needs.

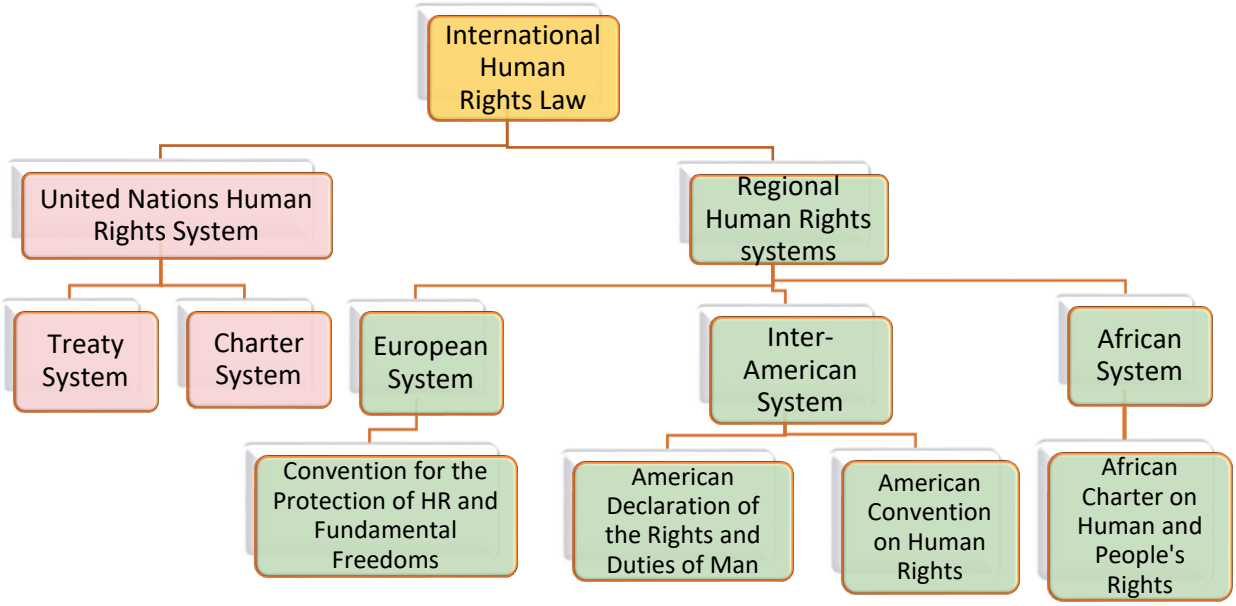
4.2 INTERNATIONAL CONVENTIONS AND STANDARDS

Signatories to international human rights conventions, international standards of good practices, as well as regional mechanisms, are legally and morally bound to fulfil the rights entrenched in them (World Health Organization, 2005:15).

Figure 1 below provides an understanding of two distinct categories of International Human Rights Systems. The first category, the United Nations Human Rights System, is made up of the Treaty system as well as the Charter system. Lines (2008:8) informs us that the treaty system is based on the following core international conventions, namely, the International Covenant on Civil and Political Rights; the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment; the Convention on the Elimination of All Forms of Racial Discrimination; the International Covenant on Economic, Social, and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the International Convention for the Protection of All Persons from Enforced Disappearance; the Convention on the Rights of the Child; and the International Convention on the Protection of the Rights of All Migrant Workers

and Members of their Families. The Charter system is founded on the Charter of the United Nations (UN), which is composed of two primary bodies, the Economic and Social Council, as well as the UN General Assembly. The UN General Assembly, which comprises 92 UN Member states, adopts human rights treaties and declarations, and plays a crucial role in the setting of standards.

Figure 1: Understanding Human Rights Systems



Source: Adapted from Lines (2008:8)

Three Regional Human Rights Systems, under Category two, are in existence, namely, the European system; the African system; and the Inter-American System as depicted in Figure 1. The principle treaty of the European system is the Convention for the Protection of Human Rights and Fundamental Freedoms, whereas that of the African System is the African Charter on Human and People's Rights. The Inter-American regional system consists of the American Declaration of the Rights and Duties of Man as well as the American Convention on Human Rights (Lines, 2008:10).

A country determines which standards or human rights' treaties it wants to adopt or engage with, thus implying that they are not forced by external countries to sign or ratify these. Once a national government chooses to ratify a treaty, it becomes

a party to the treaty and only then will the terms of the treaty become obligatory to that country (Lines, 208:8).

This section provides an explanation on the main human rights treaties that have a bearing on health and mental health rights of persons, rather than a discussion on all the International treaties, as it may become too complex for a study such as this one.

4.2.1 The International Bill of Human Rights

The Universal Declaration of Human Rights (UDHR) together with the UN human rights treaties, namely, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights are found in the International Bill of Human Rights.

4.2.1.1 The Universal Declaration on Human Rights (1948)

The Universal Declaration on Human Rights (UDHR) was proclaimed and adopted by the United Nations General Assembly in 1948. This non-legally binding document sets out the fundamental rights of all beings in Article 1-2, whilst Article 25 declares that every individual has the right to a good standard of life and medical care for health and well-being (United Nations, 2016b:52). Authors such as Zarret (2016:201) argue that although Article 25 does not clearly differentiate between mental and physical health, it is implied therein. The UDHR principles have helped shape present-day mental health law and countries have incorporated these principles into their policies.

4.2.1.2 International Covenant on Civil and Political Rights (1996)

Article 7 of the International Covenant on Civil and Political Rights stipulates that every person, including those with mental disorders, is protected from “torture and cruel, inhuman or degrading treatment”. It stipulates further that mentally ill persons have the right to refrain from being exposed to medical or research or scientific testing without consent. Lines (2008:12) argues that the health issues of

persons in detention are expressed under Article 6 (Right to life) and Article 10 (one's right to humane treatment). This is a legally binding document.

4.2.1.3 The International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights (ICESCR) which entered into force in 1976, acknowledges the right of everyone to the utmost possible quality of physical and mental health care in Article 12. It places an obligation for the designing of beneficial and benevolent treatment for mental illness, whilst also ensuring that the mentally ill are given access to affective education and job-related training programmes, yet in line with non-discriminatory practices (Lines, 2008:12).

4.2.1.4 Convention on the Rights of Persons with Disabilities (2006)

Due to delayed action in addressing mental illness, the UN General Assembly approved the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD is a mandatory document that aims to protect the rights of disabled people including persons with mental disorders. It emphasised the need to respond to the environmental obstacles that impede participation in community life. This framework speaks to issues of structural disparities, stigma, discrepancies in health, discrimination, and insufficient service provision (Ventura, 2014).

4.2.2 International Standards of Good Practice

International standards of good practice have also been endorsed as guidelines for human rights considerations. These include, amongst others, the Declaration of Madrid (1996); the World Health Organization's Mental Health Care Law: ten basic principles and World Health Organization Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (1996); the Standard Rules for Equalization of Opportunities for Persons with Disabilities (1993); the UN Declaration on the Rights of Mentally Retarded Persons (1971); and the Principles for the Protection of Persons with Mental Illness and for the Improvement of

Mental Health Care (1991). International standards of good practice have no binding force (Ventura, 2014).

4.2.2.1 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

The General Assembly espoused the United Nations (UN) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care resolution 46/119 (Mental Ilness Principles) on 17 December 1991 (World Health Organization, 2005:157). These have no binding legal effect, but offer guidance on what mental health systems should be like (Zarret, 2016:204). Principle 20 specifically refers to mentally ill criminal detainees or criminal detainees allegedly suffering from mental illness. It iterates that all detainees must enjoy their fundamental rights and not be discriminated upon due to their mental illness. Further to this, they may be subjected to treatment in an institution, but only if the detainee has consented to this treatment, unless it is an involuntary mental health care user (IMHCU). It also makes provision for domestic law to empower a court or "other competent authority" to admit them to a mental health facility (World Health Organization, 2005:17). The Principles determine the requirements for housing standards that psychiatric institutions must abide by. The Mental Illness principles generate safeguards against random detention in psychiatric facilities (Ventura, 2014:4). Principle 9(2) as well as Principle 10(1)'s depend on countries developing personalised "treatment plans" for mentally ill detainees as well as increased access to medication.

4.2.2.2 The United Nations Standard Minimum Rules for Non-Custodial Measures (The Tokyo Rules)

The Tokyo Rules are directed towards the rehabilitation of detainees and their "integration" into society. It also espouses the establishment of non-custodial measures. One of the progressives towards human rights is that the Tokyo Rules calls for strict rules to be in place to ensure the confidentiality of an detainee's personal information and access to this information must be controlled and limited. The Rules request that pre-trial detention be prevented, and if it is necessary, then

it should be used as a measure of last resort. Courts should consider pre-trial detention if it is a measure to protect society and if it is a requirement for investigation purposes. Mindful of the fact that they are not mandatory, they do produce a point of departure for non-discriminatory management of the mentally ill population and consequently assist policy developers in the creation of an instrument to benchmark against international human rights principles, as well as in the impartial monitoring of psychiatric cruelties (Salize et al., 2007:29).

4.2.2.3 Nelson Mandela Rules

The Nelson Mandela Rules is a revision of the Standard Minimum Rules for the Treatment of Prisoners (SMRs) by the UN in 2015 because of criticisms levelled against the SMRs that it was archaic (Lalla, 2017:41). The Nelson Mandela Rules serve as a guide for penal institutions, to be used when developing their policies and standards for detainees, personnel, and for the management of correctional centres, as well as laying down the rights of detainees (Republic of South Africa, 2016:13).

Rule 1 of the Nelson Mandela Rules reiterates what many standards have already done, and that is not subjecting the detainee to cruel and inhumane conditions in the endeavour to respect the innate dignity and humanness of detainees whilst also ensuring the safety of detainees and the public at large, including the personnel. Further to this, of importance is Rule 13 which must be adhered to in order to keep within international standards for the accommodation in respect of infrastructure for living quarters of detainees (Lalla, 2017:41).

Rule 5 of the Nelson Mandela Rules calls for corrections authorities to ensure their facilities cater for equal access for detainees with physical, mental, and/or other disabilities on an equitable basis, whilst Rule 25 iterates the need for health care services to cater for the both the mental and the physical wellbeing of detainees (United Nations Office on Drugs and Crime, 2016:3-8). The rehabilitation of those with disabilities (both mental and physical) must be afforded the opportunity to be rehabilitated (United Nations Office on Drugs and Crime, 2016:3-8). In line with this, Rules 31 - 33 suggest that all medical examinations must be done on a

confidential basis with detainees who have medical issues including that of mental health, and as such, a report is to be submitted to the head of the institution on any detrimental effects that continued imprisonment may have on the detainees (United Nations Office on Drugs and Crime, 2016:10). Suffice to say, in keeping with international legislation, Rule 39 cautions the disciplining of detainees who commit further infractions due to a mental illness, and Rule 45 disallows solitary confinement for those with mental illness (United Nations Office on Drugs and Crime, 2016:14).

4.2.2.4 African Regional Instruments

The African Charter on Human and Peoples' Rights (ACHPR), adopted on June 27, 1981 also emphasises the rights to equality, life, and dignity. Article 30 mandated the establishment of the African Commission on Human and Peoples' Rights (African Commission) which was set up in 1986. The purpose of this Commission was to monitor correctional centre conditions and provide guidelines on the running of correctional centres. According to Lalla (2017:44), this led to increased improvement of human rights considerations in Africa. Specific reference is made to Article 16 which iterates and upholds the principles regarding mental and physical health, and that is that all people have the right to obtain the highest level of mental and physical wellbeing. It also states that essential precautions must be taken to prevent illnesses.

Article 33 of the Luanda Declaration for Persons with Disabilities acknowledges that attending to the health of Africans is critical to Africa´s socio-economic development. Article 33 reiterates what universal guidelines have stated concerning persons deprived of their freedom. It states that every person "with a physical, mental, intellectual or sensory disability shall be treated with humanity and respect" and be accommodated in reasonable accommodation in consideration of the disability. No person will be coerced or forced to get treatment without his/her consent. This right must be respected by the State (Stephens, 2018:224).

4.2.2.5 United Nations Convention on the Rights of the Child (UNCRC)

The UNCRC overarches three rules of child justice. These are: the UN Standard Minimum Rules for the Protection of Juvenile Justice (the Beijing Rules); the UN Guidelines for the Administration of Juvenile Delinquency (also known as the Riyadh Guidelines); and the UN Rules for the Protection of Juveniles Deprived of their Liberty (Van Bueren, 2018).

A child is defined in UNCRC as someone who is under the age of 18 years. The document prescribes the right to medical treatment for children in incarceration under "the right to health" in Article 24 (Lines, 2008:15). States are obliged to ensure that processes are established to guarantee a child's right to receive primary health services. There has been a compromise on the quality of health provision to children in detention and in some cases access to basic amenities such as educational opportunities and health services are gravely lacking (Lines, 2008:24). Further to this, Article 27 embraces children in detention by indicating the entitlement of every child to a "standard of living adequate for the child's physical, mental, spiritual, moral and social development". It therefore has implications for countries to ensure that this is catered for (Children's Rights Alliance, 2010:24-27). In addition, Article 40 focuses on the administration of juvenile justice and the child's right to obtain legal assistance as well as to be treated fairly in the CJS, and that respects the rights of the child. Of paramount importance is the establishing of a "minimum age" at which children shall be presumed unable to have the capability to commit crime (Children's Rights Alliance, 2010:34-36).

4.3 DETAINEES WITH MENTAL HEALTH NEEDS

Mental health problems are increasingly more evident in detention facilities than in the community and the prevalence of mental disorders is said to be in excess among detainees than that of the general population globally (Stephens, 2018:223). Countries such as those being studied apply the concept of mental incapacity or "incompetence to stand trial" and therefore can be in a position to prevent mentally ill persons from incarceration. The determination whether

mentally ill persons should be imprisoned is considered to be largely a legal and a political one (Konrad & Lau, 2010:236). If detention is necessary for good order, then detainees could be detained in one of three institutions i.e. a general hospital psychiatric ward; a criminal psychiatric ward; or a criminological psychiatric ward in a detention facility (a hospital ward in South African correctional facility) (Konrad & Lau, 2010:236).

The World Health Organization (2007a:134) supports the reality of incarcerated life stating that detention facilities are places where the substandard and bad living environment places immense physical and psychological strain on the detainee, and thus produces a susceptibility to deteriorating mental stability. Apart from this, apprehensions about being separated from family, friends, and a support structure creates further uncertainties and adds to the already stressful conditions of prison life. The World Health Organization (2007a:134) concludes that 'prisoners are bad for mental health'.

Even though mentally ill detainees can be detained in various institutions, the misplacement of mentally ill detainees continues to be debated.

Stephens (2018:223) reports that it is only of late that the medical fraternity and corrections have accepted that mental diseases and other related problems such as substance abuse are increasing in their facilities. Many countries, including South Africa, Nigeria, and the United States of America (USA), show a high number of imprisoned mentally ill persons. This could be attributed to the incessant arrest of those suffering from a mental illness. Mentally ill persons are considered to be "disturbing" the norm and once they begin to display symptoms, they fall victims to arbitrary arrest. Thus, the inadvertent "criminalization" of mentally ill persons (Konrad & Lau, 2010:236). Other factors for the high rates of detainees with mental illness being kept in detention facilities, is firstly, related to frugal budgets for the treatment of mentally disordered persons, and therefore it is better to place them in detention for their long term care. Secondly, a reduction of hospital stay due to budget constraints allows for the patient to leave earlier to return to the community that sent them there in the first place. Furthermore, insufficient support structures for community-based care results in the treatment

not being completed which places them at a risk of retrogression (Konrad & Lau, 2010:236).

Of grave concern globally, is that general hospital psychiatric facilities are unwilling to accept mentally disordered detainees because of inadequate security, and limited resources that correctional services have in terms of qualified personnel in practical forensic psychiatric experience. Further to this, correctional employees are often not proficient in “mental harm reduction” and in advocating and promoting mental wellbeing. They even lack the skills to identify or provide aid to detainees who suffer from mental illnesses; therefore, they do not provide the much-needed attention to the mental health needs of detainees (World Health Organization, 2007a:140; thus, infringing on their right to adequate health care. Stephens (2018:223) maintains that the lack of facilities, insufficient bed space, and insufficient infrastructure for adequate assessment and treatment of mentally ill detainees in general hospital facilities, is an impediment towards achieving the principles of the Nelson Mandela Rules and other human rights instruments.

Since mental illness is associated with some kind of violence, authors such as Konrad and Lau (2010:237) indicate that a manner of dealing with mentally ill detainees is to consider diversion programmes where they will not be faced with the formal CJS mental health treatment systems. This was seen in the case of Mental Health courts in the USA as well as diversions from the CJS in Germany. The challenges facing the management of mentally ill detainees are multifaceted, and the researcher discusses the consequences for detained mentally ill persons in the following chapter.

4.4 SOUTH AFRICA

4.4.1 Detainees’ Mental Health and Human Rights

Despite South Africa being one of the 51-founder members of the United Nations (UN) in 1945, the UN General Assembly deferred South Africa from its membership on 12 November 1974. This was because of global opposition to its apartheid dogma. Since 1994, the government started the process of developing

its policies and reviewing its legislations using the UN multilateral system as its foundation (Republic of South Africa, 2016:13). Hence, the development of a new Constitution, which took effect on 4 February 1997.

The Constitution of South Africa, Act 108 of 1996, made provision for a National Department of Correctional Services. The Bill of Rights contained in Chapter 2 of the Constitution, includes the "rights of the arrested, detained and accused persons", and is protected by s35 of the Constitution. These rights elaborate on the accused person's fundamental entitlement to a fair trial. The accused must not only be physically present in court, but also of sound mind to be able to comprehend the proceedings, in an effort to make a proper defence (Khan, 2017:39). Included in these rights, is the right of the detainee to be incarcerated in facilities that are "unswerving from the conditions that are favourable to human dignity" which also includes being provided with medical treatment. Further to this, Section 35 (2e) of the Constitution makes provision for every detainee's right to receive medical treatment should it be required (Republic of South Africa, 1996). In line with this, the DCS has encapsulated this in their mission statement: "Contributing to a just, peaceful and safer South Africa through effective and humane incarceration of detainees and the rehabilitation and social integration of offenders" (Department of Correctional Services, 2014a:1). Detainees can choose to consult their own medical physician (Republic of South Africa, 1996:1261). The Constitution also makes provision for oversight bodies such as the South African Human Rights Commission whose responsibility it is to receive information from various organs of state on their measures aimed at guaranteeing human rights issues to be realised and upheld. These rights include that of health care (Republic of South Africa, 1996:1331).

Both South Africa and Nigeria are signatories to the African (Banjul) Charter on Human and People's Rights, a regional mechanism, which serves as a legally binding document intended to protect human rights. It was effected on 21 October 1986 (Callard, Sartorius, Arboleda-Flórez, Bartlett, Helmchen, Stuart, Taborda & Thornicroft, 2012, 213-214). It stipulates in Article 16 that the right to the choicest physical and mental wellbeing must be provided to everyone. Article 5 covers the right and respect for the dignity innate in people, including the prohibition of all

kinds of abuse and humiliation such as serfdom, slave trade, cruelty, and brutal or humiliating punishment (Viljoen, 1999:1-17). Although this regional mechanism speaks volumes against human rights abuses and is considered a document that addresses African human rights issues, African countries seem to be lagging behind in implementing these.

It must also be noted that in line with the UN Convention on the Rights of the Child (UNCRC), and the African (Banjul) Charter on Human and People's Rights, African countries, including South Africa and Nigeria, have adopted the African Charter on the Rights and Welfare of the Child (1990) (ACRWC) effected in 1999. To this end, Article 17 stipulates that under no circumstances may a child who is under the system of corrections be tortured or treated inhumanely. Every child must receive special treatment and to this effect every case must be considered and investigated as a unique case (African Union, 1990). The ACRWC also dedicated Article 13 to "mentally or physically disabled children" and provides for special measures to protect the mentally ill or disabled child's physical and moral needs with dignity, and Article 14 safeguards the child's entitlement to the best achievable health facilities and amenities (spiritual, mental, and physical) (African Union,1990).

Further to this, South Africa signed the United Nations' Convention on the Rights of Persons with Disabilities, and its Optional Protocol in 2007. This meant that South Africa's leadership dedicated itself to a fundamentally new approach to persons with disabilities, including mental disorders (Burns, 2010:662).

The Child Justice Act 75 of 2008, the aim of which is to try to divert children's matters away from the formal CJS, came into effect in South Africa on 1 April 2010 and is aligned to international legislation on the rights of the child (Gallinetti, 2009). The age of criminal capacity is the years when it is assumed that a child possesses the coherent aptitude to know the difference between what is right and wrong, and to appreciate the repercussions of his/her actions. Prior to the Child Justice Act (CJA), criminal capacity was governed by common law. A child who has not reached the age of 7 years was unequivocally "presumed to lack criminal capacity" and would not be held criminally accountable for an offence (Skelton &

Badenhorst, 2011:14). A child between the ages of 7 and 14 years was acknowledged as lacking criminal capacity. In this case, the state had to prove this, and if proven, the child could be held liable for a crime. A child who was 14 years and older was considered as having full criminal capacity (Skelton & Badenhorst, 2011:14).

Since the CJA, the minimum age of criminal capacity was raised from 7 to 10 years, which meant that a child who has not reached the age of 10 years cannot be indicted for contravening the rule of law. The CJA makes provision in Section 7(2) that the criminal capacity of children between 10, but below 14 years of age be ascertained within 48 hours, in the form of assessments being carried out by the probation officers working at the Department of Social Development. One of the purposes of the assessment is to recommend to the court whether "expert evidence" in relation to the criminal capability of someone who is 10 years old, yet below 14 years of age would be essential (Gallinetti, 2009: 18). Section 11(3) of the CJA stipulates that a "child justice court" may instruct by means of an order that an assessment on the criminal capacity of the child be conducted by a "suitably qualified person". This evaluation is to incorporate assessing the "cognitive, moral, emotional, psychological and social development" of a child (Skelton & Badenhorst, 2009:42).

Schoeman (2016:37) argues that the United Nations Convention on the Rights of the Child (UNCRC) General Comment No. 10 recommends the minimum age of criminal capacity to be 12 years, yet in South African it is 10 years. The CJA, however, makes provision for the reviewal of the criminal capacity age within five years of it coming into force.

The fact that all eyes are set on South Africa to lead in ensuring the values, principles, and standards set out in the Nelson Mandela Rules are affirmed in the operations of the Department of Correctional Services (DCS) of South Africa.

Pre-1996, the DCS was militarised and used force and authority to achieve indisputable obedience in the effort to enforce compliance. The use of ranks, drills, and weapons prepared for physical enforcement of rules, and as a method

to reinforce apartheid separatism in “prisoners” whilst regarding a detainee as an enemy and an outcast of society. Things began to transform post-1996. The DCS was demilitarised for a new democratic direction. Military training was discontinued, and force could not be used to enforce rules – only necessary force was allowed. The correctional official became a rehabilitator focusing on individual and tailored care to integrate the detainee as a rehabilitated individual back into the societies they came from (human rights framework). Many argue that demilitarisation brought with it challenges in instilling discipline because it eliminated command and control policies (Muntingh, 2012:2).

Having renamed the Department from prisons to correctional services, brought with it changes in terminology and definitions with respect to the human rights framework, and included the addition of a “hospital prison for psychopaths”; changing presidents’ patients to state patients; introducing the concepts of parole boards; and a system of credits; as well inserting Section 54(16) in the Correctional Services Amendment Act 68 of 1993, which includes that a convicted detainee who is suspected of being mentally unstable or whose mental state is under enquiry (observation ordered by a magistrate) will not stand as an accused before the institutional committee for disciplinary infringements, unless mentally competency is certified by a medical practitioner (Republic of South Africa, 1993a:16).

Introduced in the Correctional Services Amendment Act 68 of 1993 in regards to s63(a) makes provision for the submission of a dossier on, amongst others, the psychological condition of a “prisoner” for the possible placement under correctional supervision (Republic of South Africa, 1993a:20).

Definitions added were that of disability, which included physical, mental, intellectual, or sensory impairment. The Department was obliged to promote the mental well-being of detainees and to provide for recreational, psychological, and care services for “the social, mental, spiritual, health and physical well-being of inmates” (Republic of South Africa, 2011a:37). Section 37 of the Correctional Services Act 111 of 1998 (CSA) makes it compulsory for detainees to perform labour aimed at the development of “foster habits of industry”. It excluded any

detainee who was certified by a medical practitioner to be physically or mentally unfit. Children were not allowed to engage in work activities if the type of work was found to be hazardous to a child's cognitive, spiritual, bodily, psychological, or social well-being, or if it is unsuitable to the age of the child (Republic of South Africa, 2011a:37).

Amendments with specific reference to mentally ill remand detainees were made in the Correctional Matters Amendment Act 5 of 2011, which gave the authority to the National Commissioner of Correctional Services to incarcerate a person whose mental well-being is uncertain, or a person showing signs of mental disorders. They can be detained in a correctional health facility and not placed together with the general healthy population. Such detention should be authorised for observation purposes and for the provision of compulsory care and for medical rehabilitation (Republic of South Africa, 2011a:12). This would include social and psychological services, which would promote their mental health as well as visits by relatives to mentally ill remand detainees. Further to this, the Correctional Matters Amendment Act, indicates that no detainee may be segregated, if such segregation may pose a threat (physical or mental) to the detainee.

The DCS Regulations were subsequently amended in 2012 to include the changes made in legislation. Regulation 3(2)(1) makes provision for the segregation of a mentally ill detainee if their condition poses a risk to other detainees (Republic of South Africa, 2012:13). Other changes included mentally ill detainees being visited at least once a day by the nurse (Republic of South Africa, 2012:17). In the event that the court has sent the offender to a "prison health facility" pending a decision by the judge in chambers, arrangements must be made as soon as possible to transfer them to a designated mental health facility. In addition to this, Regulation 7(6) states that, should a mentally ill detainee be transferred to a health facility for treatment, the family, spouse, or partner must be informed.

The Mental Health Care Act 17 of 2002 allowed for a mentally ill person to be accommodated in correctional facilities (Republic of South Africa, 2002:31), provided that the DCS had the necessary resources to care and treat the

detainee. If the nature of the mental illness was such that the detainee could not be properly cared for and treated, then an order must be made out to transfer the detainee to a designated mental health establishment. The DCS Regulations 13(a) regulates that a mentally ill detainee may not be detained in a correctional centre but rather transferred to a designated health facility (Republic of South Africa, 2012:17). A detainee who is mentally ill can be considered for medical parole as stipulated in Section 79 if he/she is unable to care for her/himself as a result of a terminal disease/condition or is physically incapable to do so because of injury, disease, or illness (Republic of South Africa, 2015:52). Regulations therefore stipulate that medical parole should be considered for mental or intellectual incapacity. The Regulations require that a medical report be completed by a medical practitioner to indicate whether the illness could have a minor, moderate, or severe impact on the ability of the detainee to care for him/herself (Republic of South Africa, 2012:91-93).

Mental health in DCS falls under the programme rehabilitation. The DCS strategic objective regarding health is to grant detainees extensive "health and hygiene" provisions for as long as they are incarcerated (Department of Correctional Services, 2018c:69).

4.5 GERMANY

4.5.1 Detainees' Mental Health and Human Rights

Germany became a European Union (EU) member on 1 January 1958. This therefore means that Germany must abide to international human rights conventions, international standards of good practices, as well as its regional mechanisms. As an EU member state, Germany has committed itself to the appropriate treatment and accommodation of mentally ill persons. Germany has however, not ratified the Optional Protocol to the International Covenant on Economic, Social, and Cultural Rights (Amnesty International, 2018:5).

There are 16 individual states in Germany. Each state controls its own detention facility which reside under the authority of the State Ministries of Justice. The

facilities are however governed by a Federal Law, namely, the German Code of Criminal Procedure Act, 1998 and as amended by Article 3 of the Law of 2 October 2009 (Central Intelligence Agency, [Sa]). Since 1 September 2006 reform took place, in the sense that the prison code was a federal law, but since September was to be the responsibility of the 16 German states, and each state had to use the old prison code until they developed their own prison code. Further reform saw states being ordered to legislate the management of pre-trial detention as well as legislation for the incarceration of young detainees which had to be implemented before 1 January 2008 (Lehmann, 2012:132). There were 57 600 detainees in German detention facilities, as at 30 June 2020 (World Prison Brief, 2020b). The death penalty ended more than 66 years ago (Lehmann, 2012:131).

A separate sector of forensic psychiatric care is dedicated for mentally ill detainees. Germany is one of the member states that has the largest forensic psychiatry sector with a total of 7 299 available beds in 2003 (Salize, Rössler & Becker, 2006:96). This is in line with the European Convention for Protection of Human Rights and Fundamental Freedoms, which provides for compulsory safeguard for the human rights of mental disordered persons (World Health Organization, 2005:12).

Further to this the principles prescribed by the European Court of Human Rights with regard to mental health, state that a mental disorder must be diagnosed by an unbiased medical expert who will determine whether the mental disorder is of such a nature that it necessitates confinement. Continuance of confinement will depend on how persistent the particular mental disorder is. These principles therefore protect against involuntarily admitting persons who suffer with mental disorders (European Union Agency for Fundamental Rights, 2012:18). The Recommendation 1235 on Psychiatry and Human Rights (1994) sets out the procedures, which are to be followed in the cases of involuntary admission (WHO, 2005:12-15). Germany follows these procedures and applies the two necessary conditions as recommended which are: (1) the person must be expertly diagnosed as an individual with a mental disability; and (2) the individual is a serious danger to him/herself or to the public (Zielasek & Gaebel, 2015:15).

Germany is a founding member of the EU, and has to abide by the European Convention for the Protection of Human Rights and Dignity of the Human Being through the implementation of the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1996). This was the principal global legally obligatory instrument to embody the principles of informed consent to confinement and to any medical research/experiment (World Health Organization, 2005:13).

The Basic Law (which is akin to a Constitution) was signed in 1949 creating the Federal Republic of Germany. Its approach was a response to the harsh practices of National Socialism and aimed at moving away from authoritarianism. The Basic Law gave impetus to Germany as a parliamentary democracy. Germany's power is separated into executive, legislative, and judicial branches. It included fundamental rights (as in the Weimar Constitution) and emphasised human rights and human dignity. Together with this, it introduced women's voices to Germany. However, it did not avoid the Nazi dictatorship. The division of Germany was formalised in 1949 with both East and West Germany signing their own constitutions. This study focuses on the Basic Law of the Federal Republic of Germany (FRG). Further to this, the death penalty was eliminated by the Basic Law in 1946, although Germany's last execution was in the German Democratic Republic (GDR) in 1981 (Dessecker, 2009). Capital punishment was brought to an end in 1987. According to Wolfrum, Hestermeyer and Vöneky (2015:6-7), the human rights chapter of the Basic Law was formulated with an early draft of the Universal Declaration of Human Rights in mind and thus incorporated its principles.

It recognised the division of the different states of Germany but made provision for the accession of such states to the FRG as per Article 23. Its goal, however, was that of a unified Germany. The law was only supposed to serve as an interim constitution. In 1990, East Germany declared its accession which resulted in the unification of Germany. Thus far, it has been amended more than 60 times. Amendments between 1990 and 1994 brought with them affirmative action with regard to women's rights, and Article 3 was revised to forbid discrimination on the grounds of disability. In Germany, "disabled people" refer to those "affected by

a functional limitation originating from a physical, mental, or emotional state, which deviates from the norm for a person of that age and is not temporary". This definition is in accordance with the World Health Organization's definition of disability, which encapsulates the three stages of the disablement (i.e. impairment, disability, handicap) (Wilken & Breucker, 2000:10).

Germany's Constitution lays out the basic human rights of all persons in Articles 1 to 19, and Article 3 specifically states that no-one will be disadvantaged or disfavoured if they have a disability (mental or physical) (Federal Republic of Germany, 2015:8-15).

In Germany, convicted mentally ill detainees are not sent to detention facilities, but to psychiatric hospitals first to undergo treatment. The authority under which the mentally ill falls is that of the Ministry of Health and not the Ministry of Justice (Subramanian & Shames, 2013:14). This is in line with International Standards.

According to Lehmann (2012:132), reasonably high standards for the diagnosis and treatment of mental illnesses are found in the community, yet, many states have not duplicated these standards into the prison system. The reason for this is that the Federal German parliament decided in 2006 to restructure relations between the states (*Länder)* and the federal government. Prison legislation was apportioned to the individual states (Lehmann, 2012:132).

Suffice to say, although the 2006 reform was an opportunity for states to develop regulations for the more proficient management of these detainees through the process of monitoring mandatory treatment, many states did not do so. According to Salize et al (2007:238), only Baden-Württemberg, Bavaria, Berlin, and Saxony of all Germany's federal states have psychiatric units in their penal institutions. The other states make use of health institutions outside of the detention facilities and consult with specialists to provide for psychiatric care of detainees. Therefore, uniformity in implementing the rights of detainees are lacking with respect to the treatment of the mentally ill (Salize et al., 2007:238).

In line with the basic rights to health, German criminal law prescribes a medical examination of detainees upon admission to a detention centre. Part of the compulsory health examination includes getting information on the health history (including addiction history) to ascertain the possibility of the detainee suffering from withdrawal symptoms or the likelihood of the detainee becoming dependent on drugs. The inhouse doctor must also make a diagnosis of a suicidal risk. However, German criminal law does not prescribe consistent psychiatric testing for every single detainee upon admission. In the case of outpatients, psychiatric care and treatment in a correctional facility is provided only if the detainee is recommended to a psychiatrist for such treatment by the general physician (Salize et al., 2007:155).

Security concerns are of continuous debate in Germany. Detainees receiving inpatient care in public psychiatric facilities are not well received by the public and by the medical fraternity. It is argued that detainees annoy other patients, they are less disciplined and need more attention from the medical staff. It is also argued that detainees are admitted under inpatient care as a reaction to a self-inflicted risk such as that of attempted suicide or “auto aggression” (Lehmann, 2012:134).

According to Salize et al (2007:156), there are several lobbyists in Germany that campaign for the needs of mentally ill detainees, who on their own cannot address all challenges. The insufficiencies in German inpatient psychiatric care for those that are incarcerated include the dearth of amenities for treating long-lasting mental disorders and unsatisfactory handling of severe psychotic detainees. This results in detainees being accommodated in secluded cells (Salize et al., 2007:159)

Structures such as special outpatients’ clinics were set up to afford parolees the opportunity to still adhere to parole conditions. However, there is no uniformity in the application due to regional differences caused by the Federal vs. State systems (Konrad & Lau, 2010:236).

As previously discussed, the construct of legal criminal responsibility can be seen as a diversion method, which seeks to remove the detainee from the CJS at any

stage of the trial. Having used this in Germany, there was an outcry from the public of the threat posed by conditionally released mentally ill detainees to the community. Added to this, was the outcry from the community on the violent acts that could possibly be posed by the paroled mentally ill if they had not undergone proper treatment. These changes were brought about by the Reform of the Parole System and Amendment of the Provisions for subsequent Preventative Detention Act. This therefore required that the authorities allow for longer periods of community supervision by both the courts and a parole officer (Konrad & Lau, 2010:238).

According to Konrad and Lau (2010:238), there has been an escalation in the totals of mentally ill in criminal psychiatric hospitals, and the numbers continue to rise steadily, whereas the numbers of detainees in penal institutions have decreased.

Rule 109 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) talks of “prisoners with mental disabilities and/or health conditions” who must be relocated to mental health institutions and not be detained in corrections (United Nations, 2016a:32). It also makes reference to medical services that must ensure the proper diagnosis and treatment of mental idiosyncrasies. In addition, the medical unit/section/facility must afford services that are similar to those of the health services in the community or the country, and Rule 45 states that persons with mental disability must not be kept in “solitary confinement” (United Nations, 2016a:32). The World Health Organization (2007a:136) indicates that in order to achieve a level of care equal to or similar to that available in the community, will necessitate the establishment of outpatient clinics. These outpatient clinics could also be used by parolees/probationers and detainees after their release from detention. In Germany, the likelihood of being released earlier is possible when compliance with the treatment is good (World Health Organization, 2007a:136). In light of this, it is found that the German authorities have succeeded in providing federal legislation in this regard.

4.6 NIGERIA

4.6.1 Detainees' Mental Health and Human Rights

Nigeria joined the United Nations (UN) as a member in 1960 and is therefore compelled to act in accordance with the UN Universal Declaration of Human Rights. Nigeria is also a party to many human rights' regulatory documents, such as the UN Standard Minimum Rules for Treatment of Prisoners. The country has also endorsed numerous international and regional human rights instruments such as: the International Convention on the Elimination of All Forms of Racial Discrimination (CERD); the African Charter on Human and Peoples' Rights; the Convention on the Rights of the Child (CRC); the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESR); the African Charter on the Rights and Welfare of the Child (ACRWC); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and its Optional Protocol (Obioha, 2011:100). It must however be noted, that merely 24 of the 36 states have accepted these into state laws. None of the other 12 northern states have documented these into their laws (Amnesty International, 2014:55).

Northern Nigeria is inhabited mainly by Muslims and the Southern part by Christians. Nigeria has two sets of legislation regulating criminal law. The legal system in the South is based on the Anglo-Saxon common law. The Criminal Code Act of 1990 and the Criminal Procedure Act of 1990 is applicable to the South, with the exception of Lagos State, whilst the Penal Code (Northern States) Federal Provisions Act of 1960 and the Criminal Procedure Code of 1960 is applicable to the Northern Region. The North has a dual judicial system of common law and of Islamic law (Bello, 2013:18).

The 1999 Constitution of the Federal Republic of Nigeria has undergone two amendments before it was signed into law in 2011. The Bill of Rights applicable to all citizens of Nigeria is found in Chapter IV. The Constitution specifically mentions health in Chapter 2(3)(d), directing that states provide policy that covers

suitable medical and health facilities for all persons without any prejudice or discrimination. Although the section does not specify mental health, it is covered under Section 3.

The Constitution explicitly allows the death penalty by stipulating in Section 33(1) that "(e)very person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria". Carrying out the death penalty in a manner that amounts to "cruelty or inhumane or degrading treatment" violates a person's constitutional protection (Bello, 2013:28).

Criminal laws allowing the death penalty at the federal and state levels in Nigeria are in conformity with Article 6 of the International Covenant on Civil and Political Rights (ICCPR) which allows countries to use the death penalty. Nigeria has therefore not ratified the Second Optional Protocol to the ICCPR which provides that no individual shall be executed and obliges the state to take all essential steps to put an end to the death penalty within its jurisdiction (Bello, 2013:28).
Section 34, in line with international legislation (Article 10(1) of the ICCPR), promulgates the right to human dignity and respect for the person and therefore no one is to be exposed to torture, inhuman or degrading treatment (Federal Republic of Nigeria:1999). However, torture is not defined in Nigerian law or criminalised, which is a requirement of Article 4 of the CAT.

Section 35 dictates that no one shall be dispossessed of their freedom. It however, makes provision that "persons of unsound mind" or individuals dependent on substances such as alcohol or drugs shall be deprived of their freedom should this be a requirement for the purposes of treatment and care or for the security of the community (Federal Republic of Nigeria, 1999). Section 36 elaborates on the "rights of the arrested, detained and accused" and includes the right to a fair trial, yet detention practices still lack transparency (Amnesty International, 2014:56).

Although human rights provisions intended at forming a society which protects political autonomy and social and economic eudemonia are enshrined in Nigeria's

Constitution, it has failed to see it come to fruition. According to Amnesty International (2014:5-55), there are many human rights abuses, there is disparate access to basic health care, inequitable delivery of health resources, insufficient health facilities, scarce health personnel, and poor consideration for the wellbeing and care of detainees, the impoverished, the mentally disabled, and other vulnerable groups.

The UN Standard Minimum Rules for the Treatment of Detainees (Nelson Mandela Rules), specifically Rule 12, outlines the physical requirements of prisoners' accommodation, yet violations in this regard still take place (United Nations, 2016a:5).

Nigeria is not party to the Second Optional Protocol to the International Covenant on Civil and Political Rights which aims to eliminate death as punishment. It has retained the death penalty for murder, treason, aggravated robbery, and any other serious offences, which has caused great public concern (Coldham, 2000:230).

It is evident from the literature provided, that correctional psychiatry provisions are demanding in Nigeria because of the lack or unavailability of exclusory mental health legislation. The Nigerian population is part of the 59% worldwide that live in a country with obsolete and outdated mental health laws for the management of corrections psychiatry, and thus this is not in line with international standards that require modern ways of dealing with mental illness (Olagunju, Oluwaniyi, Fadipe, Ogunnubi, Oni, Aina & Chaimowitz, 2018:80). Similarly, Durcan and Zwemstra (2014:88) maintain that aspects crucial to maintaining mental health include amenities that facilitate self-development and self-progress as well as protection from danger, environmental dependability, and predictability. Nigeria does not uphold the international instruments in this regard.

In a Nigerian study involving 275 detainees and officials conducted in January 2016, it was found that 83% of the respondents indicated and strongly agreed that detention laws in Nigeria must be reviewed to map out a path for rehabilitation as opposed to penalisation (Onyekachi, 2016:11).

The Nigerian Prisons Service Standing Orders, which were revised in 2011, outline procedures in relation to medical services and include aspects of mental health. Order 50 states that every detainee must be examined by a medical doctor and any medical or mental health reports that are with the detainee must be given to the medical officer at the medical screening conducted upon admission (Federal Republic of Nigeria, 2011:1452).

Section 479 alludes to determining the mental status of an detainee. Should an officer suspect that a "prisoner" is mentally unsound, he/she must inform the Superintendent-in-charge hereof. The Superintendent-in-charge will request the Medical Officer to examine the detainee (Federal Republic of Nigeria, 2011:1512).

Section 485 deals with the handling of detainees who show noticeable signs of depression or emotion. It indicates that such detainees must be placed in association with other detainees in a similar situation in the hospital. Such persons must be under constant observation. If there are no other detainees with similar tendencies, then a transfer must be arranged and approved by the Controller of Prisons in the State to transfer the detainee (Federal Republic of Nigeria, 2011:1513).

The Standing Orders also make provision in Section 481 to report to the Controller of Prisons in the State via the office of the Superintendent-in-charge of any injury sustained by a mentally ill detainee that is to be transferred to a psychiatric hospital. Further to this, a report of any such injuries must be sent to the psychiatric hospital (Federal Republic of Nigeria, 2011:1512).

Measures to consider the wellbeing/safety of a detainee who is mentally ill are provided for in the Standing Orders. Standing orders stipulate that a mentally ill detainee must not be given any form of labour whilst incarcerated, nor must any adverse news be relayed to a mentally ill detainee who is under observation, without the advice of the medical officer. Standing orders also state that a mentally ill detainee who has been discharged on medical grounds from detention, must be escorted home (Federal Republic of Nigeria, 2011:1456 -1509).

Section 463 of the Nigerian Prison Standing Orders requires that a bell be placed in the cell of every confirmed mentally ill detainee. Should a bell not be available, then officials are required to visit the cell of mentally ill patients every 30 minutes. All detainees under observation must be visited by both the Superintendent-in-charge and the Medical Officer as often as is practical (Federal Republic of Nigeria, 2011:1456 -1510).

Mentally ill detainees in a medium or maximum facility who display mentally ill behaviour can be temporarily removed to the most suitable "Convict Prison" that has space for accommodating psychiatric patients as indicated in Section 488 (Federal Republic of Nigeria, 2011:1513).

4.7 UNITED STATES OF AMERICA (USA)

4.7.1 Detainees' Mental Health and Human Rights

According to Zarret (2016:222), the USA only started focusing on mental health when the reform regarding deinstitutionalisation was enforced in the 1950s. Prior to this, the mentally ill were treated in their homes.

The Los Angeles County Jail, known as "Twin Towers," accommodates the highest number of mentally ill persons. Of the approximate 1400 mentally ill patients, only a few detainees indicate they receive treatment while incarcerated (Zarret, 2016:222). This led to Congress passing mental health legislation in 2004 specifically applicable to detainees. The Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) is the first stride made by the federal government to gauge and evaluate the funding required for the treating of mentally ill and substance dependent detainees. There are mentally ill defendants who choose court-supervised treatment instead of the CJS. Therefore, courts had to be established for this intention and thus the establishment of such "mental health courts". The MIOTCRA provided for the instituting of mental health courts, training for mental health personnel, in-prison treatment, and after-care services. There are in the region of 150 such mental health courts across the USA (Zarret, 2016:232).

The USA's effort to transform mental health care with the development of the MIOTCRA statute has yielded some positive changes. However, serious mental illness still plagues more than 45% of incarcerated detainees (64% of local detainees, 56% of state detainees, and 45% of federal detainees) (Zarret, 2016:232).

Despite the expectations of various human rights legislation and guiding documents on the management of mentally ill detainees, the USA was found to be non-compliant by the Human Rights Watch (2019:628).

The USA has endorsed the Universal declaration of Human Rights and the International Covenant on Civil and Political Rights (ICCPR). Article 10(1) of the ICCPR necessitates the proper medical care of mentally ill detainees, as well as incarceration under humane conditions. The USA has not, according to Human Rights, positively responded to this, citing high costs of staff, and building of facilities to accommodate the needs of the disabled detainee population. The USA stands accused of not taking the needs of the mentally disabled into account, "prolonged cellular confinement", and the extremely punitive conditions imposed on detainees in super maximum facilities, which ultimately lead to further mental distress of detainees (Lines, 2008:31). Lux (2012:19) attests to this, but also argues that solitary confinement is used more as a short-term punishment for immediate disciplinary infractions and not a as a long-term method of incarceration.

The USA is also a party to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment (CAT). The deterioration of impairment, either physical or mental due to the conditions of detention or ineffective treatment administered, is regarded as a violation of Article 7 of the CAT. The USA has been found in violation of this, as stated by Heines (2005:1685) and Gavin (2011:255). The high rate of mental illness among the detainee population is said to be 3 to 5 times more than the general population due to various reasons which include the lack of sufficient treatment for detainees who are mentally ill, sporadic treatment, and underfunding (Gonzalez & Connell, 2014:2328; Heines, 2005:1685).

Solitary confinement for juveniles, mentally ill detainees, and death row detainees or those with life sentences, is not allowed by international bodies, specifically when it is gratuitously prolonged without rationalisation, and where the entirety of the conditions of detention turn into intolerable cruelty. US courts have found that keeping the mentally ill in solitary confinement is in itself “cruel”. Still detaining juvenile detainees and adult detainees in solitary confinement, and using this as a typical detainee accommodation and discipline tool, thus finds the USA in violation of the CAT, ICCPR, the Universal Declaration of Human Rights, and CPRD amongst others. Further to this, approximately 80 000 detainees were detained in the USA in 2013 (Conley, 2013:415-422).

The USA is a signatory to the ICESCR but has not, as yet, ratified it. This, however, still renders it to honour the principles contained in the Covenant. In light of this, Article 12 bears reference to affording detainees and detainees preventative, therapeutic, and palliative health services (i.e. the right to health irrespective of one’s legal status). One cannot therefore limit equal accessibility to health services. Authors such as Golembeski and Fullilove (2005:1701) and Labelle (2008:96) indicate that there are still racial disparities in health access, as well as discriminatory treatment inside detention facilities in the USA; therefore, being in contravention of Article 12 of the ICESCR and Principle 9 of the UN Basic Principles for the Treatment of Prisoners.

The Constitution of the USA in its Eighth Amendment, guarantees every detainee paid-for health care, yet the Medicare excludes payment for those that are incarcerated (Gavin, 2011:249). This amounts to a decrease in accessibility to Medicaid, which in turn has repercussions for millions of Americans, as drug treatment will become increasingly more expensive to access (Human Rights Watch, 2019:628). Therefore, the increased budget spent on detainee health care is creating cause for concern to both state and federal funding. Mass incarceration and increasing deinstitutionalisation of the mentally ill has added to the rising costs. In addition to the above, results from a study conducted by Al-Rousan, Rubenstein, Sieleni, Deol and Wallace (2017:6-7) show that detainees with a mental disorder are more likely to break correctional facility rules, and are

more prone to injuries and verbal assaults when involved in fights. Such persons are often referred for clinical treatment, which is costly, therefore rendering the correctional system open to increased costs.

Biswas, Drogin and Gutheil (2018:449) support this by stating that the absence of or delay in providing clinical treatment for the mentally ill makes them more prone to misbehaviour, recidivism, and suicide after release. Only one of six detainees receive mental health care, and many have to wait for treatment or support. Findings from a study on youths detained in Indiana between 2008 and 2012 also support research that shows behavioural health problems that are not treated and diagnosed, negatively affect integration into society (Aalsma, White, Lau, Perkins, Monahan & Grisso, 2015:1372). In this study, it was found that only 16.1% of detainees who screened positive for mental illness were able to obtain health services during their detention.

The USA is a signatory to the UNCRC but has not yet ratified the Convention. According to the Human Rights Watch (2019:622), approximately 32,000 children under 18 are detained yearly in adult jails and approximately 1,300 people were sentenced for life without parole for crimes which were committed when these people were under 18 years of age. This increases the risks of children being exposed to physical and sexual abuse as well as increased suicide. Further to this, the Inter-American Commission on Human Rights (2018:102) indicates that children are also held in solitary confinement in adult facilities, which are not according to the specifications in the NMR. Along with other deprivations, these children are deprived of their education, right to mental health amenities and medication.

Approximately 6,9 million people in the US are incarcerated, on probation, or on parole (Golembeski & Fullilove, 2005:1701). A large increase in detained persons together with the rising costs of incarceration made it difficult to implement the rehabilitation agenda of the US Corrections Department and was soon replaced by punishment in the 19th century (Labelle, 2008:85). Those detained were prone to long term isolation in dungeon-like holes, whippings, insufficient food, racial discrimination, and extensive violence (Labelle, 2008:86).

In 1960, the prisoner rights movement came into existence. This, coupled with the riots that took place at the Attica State prison in New York in 1971, started changes in the treatment of detainees (Labelle, 2008:86). From 1987 onwards there was a move to monitor and investigate the US compliance with international standards by agencies and organisations such as the Human Rights Watch and Amnesty International (Labelle, 2008:94-97).

Human rights violations in American detention facilities, according to Smith and Hattery (2007:280), include cheap labour for corporations. Other human rights violations include discrimination against sexual minorities who experience greater victimisation, mistreatment, they receive harsher punishment than the general detainee population, and are more prone to high rates of solitary confinement (Meyer, Flores, Stemple, Romero, Wilson, Herman, 2017:262). The validity of solitary confinement as a disciplinary measure is being rallied against and disputed by human rights advocates resulting in a reduction in its use (Conley, 2013:415).

The rampant disregard for human rights such as lack of access to medical care, use of force, and personal suffering have resulted in detainees in over half of the jails in the US having to file lawsuits during the period 1999 to 2001. Matters that were reported on also included, detainee on-detainee brutality, and destruction of property (Mellow et al., 2017:70).

In light of the above discussion, the USA must develop domestic legislation that will focus their undivided attention on addressing the concerns of incarcerated children with due respect for their human rights. Special mechanisms or systems ought to be put in place that will treat children as a specialised group of individuals, in order to protect their rights and safeguard against infringements of their physical and mental health rights. In addition, Al-Rousan et al (2017:8) maintain that the public health and corrections systems have placed emphasis on different ways in which to approach the issue of mental health and therefore federal guidelines should be enforced in the development and review of state-level legislation and policies (Inter-American Commission on Human Rights, 2018:138).

4.8 CONCLUSION

In the literature reviewed, International Legislation is clear on the issues of human rights for mentally ill persons and detainees. The key human rights were identified and discussed. These rights include: the mentally ill detainees entitled to the protection of their basic human rights; their right to the utmost possible standard of mental health care; protection against torture, cruel, inhuman, or degrading treatment or punishment; and protection against any form of discrimination. These have been captured in the various legislations of each country studied, yet the multifariousness of mental health legislation adds to impediments in its practical application. The existence of International Guidelines does not necessarily guarantee the protection of the human rights of people with mental disorders, neither does it mean that legislations will ensure compliance and operationalisation of such legislation. Recent reforms in South Africa (after 1994) paved the way for such, and legislations continue being amended to align to International Standards. In Germany, also regarded as one of the more progressive countries with Federal Legislations guidelines, it is clear, that although they have one of the largest forensic psychiatric sectors, not all states align their legislations to International Guidelines. Nigeria too, consists of states who have not processed the International Guidelines and Federal Guidelines into their legislations to an extent that there is no modern mental health legislation. Suffice to say, the USA, although signatories to progressive International Guidelines, is still found wanting, due to non-compliance, specifically in the case of disparities in health access, amongst others.

Often extensive time is spent on the drafting of legislation, while little preparatory work is done with regard to implementation. Implementation problems tend to occur, and these complications will be discussed further in Chapter 6.

CHAPTER 5

MENTAL ILLNESS IN THE DETAINEE POPULATION

5.1 INTRODUCTION

Jean Cortson, a Member of Parliament (United Kingdom), iterated the concern that because of the varied challenges faced by governments in managing issues of mentally ill persons, governments are misdirected into depending on the corrections system to care for the mentally ill. Cortson postulates that exceptionally vulnerable people enter the correctional system already with a history of vulnerabilities that include risks of suicide, mental disorders, and drug and alcohol problems. He indicates further that correctional centres are not suitably structured to meet even their elementary needs, let alone to rehabilitate them (Brivik, 2005:43).

Riecher-Rössler and Rössler (1993), as cited in Zinkler and Priebe (2002:4) indicated that the three criteria for compulsory admission of psychiatric patients are: (1) severe mental disorder; (2) the danger the detainee poses to him/herself or the public; and (3) an imperative need for treatment.

Besides posing a risk to themselves, people suffering from any form of mental disorder pose a substantial risk to their family and others within their communities (World Health Organization, 2005:33). Coupled with this, the majority of countries in the world do not have sufficient public mental health facilities to cater for the volumes of mentally ill persons in the communities. Furthermore, mental illness is associated with public disturbance and many countries list public disturbance as a crime (World Health Organization, 2005:75).

The Criminal Justice System (CJS) places emphasis on deterrence and punishment, and detainees with serious mental illness are often maltreated. This renders them to exclusion from the job market as well as “dumping” them at the most “convenient institution/s” to handle such persons, albeit that this risk may be minimal or that these convenient institutions may not be sufficiently resourced to

provide even the minimal care that they are compelled to get. More often than not, these institutions are the corrections facilities. Usually, people with mental disorders encounter harsh, if not the harshest, living environments in detention. Although “rehabilitation of prisoners” is a key phrase in all the countries being studied, they still cite a shortage of specialised staff and proper mental facilities/resources as obstacles for proper care and treatment. Konrad and Lau (2010:236) indicated that studies on the development of psychiatric care in different countries increasingly report negative associated effects and trends, including failing to provide proper treatment and care for mentally ill detainees.

Severe mental illness requires treatment and interventions that are different from general mental health maintenance; however, the two do not exist in isolation and cannot be seen as two separate disciplines in a corrections (Kim, Becker-Cohen & Serakos, 2015:3). One has to understand at the outset that health conditions which existed prior to imprisonment, are aggravated by the corrections environment and can result in detainees acquiring multiple prognoses and co-occurring disorders (Kim et al., 2015:3).

This chapter provides information on the mentally ill detainee population in South Africa, Nigeria, Germany and the United States of America (USA). In addition, statistical information will be provided on sentencing, the numbers of mentally ill detainees, as well as correlates to crime.

5.2 MENTALLY ILL DETAINEES: AN INTERNATIONAL OVERVIEW

The world’s population stood at 7,633 billion in the year 2018, and of these, more than 10 million are detained in the 223 corrections systems around the world (Roser, Ritchie & Ortiz-Ospina, 2019; Walmsley, 2019b:1). Approximately 5 million of these detainees suffer with some form of personality disorder whilst more than a million suffer from a severe mental disorder (Fazel & Seewald, 2012:364).

There is an upsurge in the average number of mentally ill persons globally per year. The increase is said to be by 1 million on average every year (Fazel et al.,

2016:872). World figures show that every 7th detainee suffers from major depression or psychosis (Fazel & Seewald, 2012:368). This rate has remained constant over three decades, according to Fazel et al (2016:873). It is also confirmed that nearly all detainees detained in corrections experience depression or stress symptoms, however many of these remain undetected and the detainees do not access any kind of treatment (Blaauw & van Marle, 2007:133). Furthermore, the quality of the treatment provided to mentally ill detainees is questionable. According to Fazel et al (2016:871) the rate of existence of all mental disorders within the corrections system is more substantive than that of the general population.

Statistics show that 3,6% of male and 3,9% of female detainees are inflicted with psychotic infirmities, while 10,2% of men and 14,1% women have major depressive disorders (Fazel et al., 2016:872). Furthermore, Fazel and Danesh (2002) as cited in Blaauw and van Marle (2007:33), reveal that 42% (women) and up to 65% (men) possess a personality disorder. In addition, 21% (women) and 47% (men) are inflicted with antisocial personality disorder. These figures present a bleak picture of imprisonment being undoubtedly associated with mental health disorders.

5.3 SENTENCING

The aim of penology, as a sub-component of criminology, is to create a crime-free society. In so doing, it allows for the CJS to recognise that punishment must be meted out to criminals, and at the same time society wants justice to be done (Scott, 2008:18). The public often asks for severe punishment as a means to attain one of the aims of the CJS, and that is “the protection of society”. This results in longer sentences for more violent crimes which inadvertently give the public a sense of satisfaction that imprisonment is a serious form of punishment.

The retributive theorists believe that punishment must be based on the seriousness of the criminal act, i.e. applying the doctrine of proportionality (Bagaric, 2000:143; Caruso, 2018:2; Lippman, 2006:59). When sentencing an accused, a judge could as well be cognisant of an accused’s mental vulnerability

and should consider the harsh conditions which detainees are faced with, as well as the fact that prison violence can perpetuate those already inflicted. These risks must be factored into the decision on sentencing options and when selecting an alternative sanction as a measure to avoid imposing disproportionate or inhumane punishment (Johnston, 2013:197-200; McNeill, 2014:4205; Van Ginneken, 2016:7).

Johnston (2013:153) argues that a judge may have no choice but to consider imprisonment as the only sentencing option, especially when the accused is seriously mentally ill and has committed serious crime. Johnston (2013) further states that judges are in no way obliged to allow this vulnerability to be factored into sentencing with the intention of effecting “proportionate” punishment. At the same time, the author acknowledges that the court should consider empirical evidence indicating the severe detriment that imprisonment presents to detainees that are afflicted with serious mental disorders, as well as those with less severe mental disorders at a sentencing hearing (Johnston, 2013:197-229). Judges handing down sentences must consider that detainees with a mental disorder will experience greater difficulty with adjusting to life in imprisonment as they may lack the skills and capability to do so (Johnston, 2013:151). Persons with mental disorders have a decreased capability of, amongst others, reasoning, coping skills, adaptation functioning, conformance to set standards, and judgment (Boat, 2015). It therefore places the detainee with a mental disorder at a greater risk of being physically and sexually assaulted, and if he/she retaliates, it is easier to blame the one that is mentally ill. One of the disciplinary actions instituted against these persons is solitary confinement, which in itself causes psychological debilitation (Johnston, 2013:147). Mental health disorders may also affect a detainee’s likelihood for rehabilitation (both rehabilitation from the disorder as well as reforming the detainee).

Mental disorders are often used as a mitigating factor in sentencing, with the aim that a more merciful sentence will be handed down. This will often depend on whether the relevant condition is considered treatable. Conversely, judges may tend to hand down a more severe sentence if they are informed by expert evidence that a mental health condition is untreatable, the detainee poses a great

risk to the society, or that the detainee is likely to re-offend (Walvisch, 2018:2-3). This in due course magnifies one's judgment into believing that they are dangerous persons, and therefore the CJS thinks of them as dangerous criminals to the extent that they also receive a longer sentence than those of the general population (Ghiasi & Singh, 2019). Despite having expert evidence on hand, judges may not even require a diagnosis of the mental disorder. What would be considered is how the disorder impaired the detainee during the time that the offence was committed, or the future effect of the impairment on the detainee (Walvisch, 2018:3).

Mentally ill individuals cannot always be held accountable for their crime. Whether one is found to have committed a crime will depend on whether the crime was committed out of free will, whether there was any moral competence, and whether the person had control of his/her actions at the same time as there is wrongful intent (Stevens, 2013:12).

5.4 CORRELATES TO CRIME

Various studies that have examined the prevalence of violence in mentally ill persons reported contrasting results. Researchers such as Ballard and Teasdale (2016:23) estimated that men and women who suffer with critical mental disorders are 10% - 20% more likely to be arrested than "non-disordered" individuals. Ghiasi and Singh (2019) also argued that the police often arrest the mentally ill for minor crimes which include "jaywalking or wandering behaviour" to maintain order. However, Varshney, Mahapatra, Krishnan, Gupta and Deb (2016:223) indicated that a very low level of violence is ascribed to persons suffering from mental disorders. Statistics revealed that 10% of persons with schizophrenia displayed violence as opposed to 2% of the general public. Further to this, the authors added that 2.3% - 13% outpatients displayed violence whereas 10% - 36% of patients in "acute care" showed some kind of violence and 20% - 44% of involuntary mental health care users behaved violently. Silver (2002:207-208) explains that patients who are coerced into being hospitalised reported feeling angry and fearful, and as a result, triggering a violent reaction towards those that were caring for them.

According to researchers such as Silver (2002), Sirotich (2008:171) and Varshney et al (2016:223-224), predictors of violence are varied and not solely attributable to a mental disorder. In order to understand the relationship between violence and mental disorders one needs to consider its link with other variables (Elbogen & Johnson, 2009:154). Violence is triggered by both clinical and non-clinical variables. Non-clinical variables include gender, age, socio-economic status, past violence, neighbourhood poverty, discrimination, victimisation, being in detention, and physical abuse. Clinical factors include comorbid substance abuse as well as other underlying psychiatric illness. The association of mental illness with violence was also found to be very low if it is looked at in isolation (Sirotich, 2008:171). One therefore has to look at mental illness and crime reciprocally with other variables (Elbogen & Johnson, 2009:154). The mentioned variables are by no means the only variables and for purposes of this research study not all variables will be discussed.

Stevens (2013:71) indicates that mentally ill males offend more than mentally ill females. Sirotich (2008:172) attributes this to mentally ill males being more likely to commit serious injury on another person and therefore more likely to be arrested. Fazel and Grann (2006:139) in their study, found that women with severe mental illness committed only about one-ninth of the violent offences than men with severe mental illness, although females were at more risk than males to commit violent crime. Sirotich (2008:172) on the other hand, indicates that the relationship between gender and violent crimes is not very clear. He, nevertheless, indicates that mental disorder had more of an effect on the criminal potential of females. Further to this, it is argued that the police are more likely to categorise deviant behaviour as criminal when it is committed by a mentally ill male and more of a psychopathological disorder when committed by a female, resulting in the male being arrested and charged (Sirotich, 2008:172).

According to Sirotich (2008:173), it has not been clearly proven that age is clearly linked to violence. He does, however, indicate that the mentally ill in their late teens and early twenties are more likely to be at risk for criminal and violent behaviour. There is no specific age at which males were more likely to begin their

criminal careers, however women aged 25 – 39 years and those 40 and over are most likely to commit serious crime (Sirotich, 2008:173).

According to Silver (2002:191), people suffering from mental disorders are more likely to live in poverty stricken, crime-prone neighbourhoods, whose social interaction is limited to people who are likely to use violence to resolve conflicts. Silver (2002:192) bases his argument on Felson's (1992) "Social interactionist theory of violence" and Agnew's (1992) "general strain theory of crime and delinquency". Both these theories agree that one has to consider the situations around which violent acts are committed. Whilst Felson (1992) indicates that violence is used by people as a social control mechanism, Agnew (1992) indicates that violent behaviour and negative emotions of anger and rage are a consequence of being subjected to stressful, violent situations. This too is justification for mentally disordered people becoming victims of violence. The mentally ill are at higher risk of involving themselves in social interactions in which others try to control their behaviour (Silver, 2002:192). This is also applicable to mentally ill detainees.

Fazel et al (2016) concluded that the misuse of alcohol and illegal substances is highly correlated with both violent and nonviolent offending. A finding that is also supported by Stevens (2013:17). On the other hand, researchers found that comorbid substance abuse and/or dependence in particular, increases the risk of violent crime in those with severe mental illness (Elbogen & Johnson, 2009:154; Fazel & Grann, 2006:1401). Substance use may further stimulate psychiatric patients to conduct themselves in ways that prompt others to control them socially (Silver, 2002:205). Further to this, comorbidity (more than 1 mental disorder) increases the chances of violence. Corrigan and Watson (2005:158) found that mentally ill persons suffering with more than three psychiatric diagnoses were 2 – 4,5 times more likely to also report violent behaviours.

In a study conducted by Fazel and Seewald (2012:367) on literature from across the globe during the period from 1966 to 2010, it was found that the rates of mental illness in detainees were significantly greater in low- and middle-income countries (5,5%) than in developed ones (3.5%); thereby indicating a possible link

among poverty and crimes committed. This can be attributed to the absence of psychiatric services in communities of the lower- and middle-income countries, which will leave serious mental illness untreated, especially among those with co-occurring disorders and who may experience a high rate of relapse. This, in turn, can lead to behaviour that people interpret as undesirable or offensive and more violent interfaces with the law, and of course the ultimate arrest and detention (Lurigio, 2011:68S). Further to this, Bertram (2020) indicates that previously incarcerated people are nearly ten times more likely to be homeless, and rates of homelessness are especially high among the impoverished. Lack of housing can significantly worsen mental health problems (Bertram, 2020).

The public perception of mentally ill persons being more inclined to commit crime of a serious nature associated with violence and aggression is exacerbated by the explication in the media of such persons as being “crazy”. This perseverant prejudice is a foremost cause of the stigma attached to the mentally ill and for whom detention seems a most appropriate solution (Salize & Dreßing, 2005:12; Varshney et al., 2016:223). Mentally ill persons were more likely to be victimised and discriminated upon (Silver, 2002:193).

Elbogen and Johnson (2009:156) argue that a mentally ill person’s risk towards violence is exacerbated by a past history of violence such as physical abuse and parental criminal acts. Corrigan and Watson (2005:156) found that the severely mentally ill were up to six times more likely to have engaged in violence in the previous year.

Barret, du Plooy, du Toit, Wilmans, Calitz and Joubert (2007:56) found in their study, that mentally ill detainees spent an average of two years in hospital. They further suggest that persons who are charged with violent crimes will be kept for a longer period in hospital. Being exposed to violence in the correctional system and fellow criminals in the same cell/environment, they are more likely to experience abuse from guards, and other detainees, and are at an increased risk of suicide (Torrey et al., 2014:21). Numerous detainees with serious mental illnesses pose major management problems and are difficult to control because of their diminished thinking (Turner, 2008:431). This argument further reinforces the

two theories outlined by Silver (2002). It is therefore conclusive that the relationship between mental illness and violence must be understood in relation to other variables such as socio-demographic and criminogenic (crime related) factors.

The number of mentally ill detainees in the correctional systems of South Africa, Nigeria, Germany, and the United States of America (USA); sentencing; as well as correlates to crime, will now be discussed in detail for each of the countries.

5.5 SOUTH AFRICA

All detainees are given access to health care services (Department of Correctional Services, 2019a:27-29). The South African detainee population has grown in the past years from an average of 152 554 in 2013/2014 to 162 875 as at 31 March 2019. This trend indicates a fast increase in the detainee population (Department of Correctional Services, 2018b:30; Department of Correctional Services, 2019a:47). Of these, 29% were remand detainees. World Prison Brief (2020d) confirms the dire situation that South Africa is in by indicating that South Africa when compared internationally, has the most detainees in Africa. South Africa had an incarceration rate of 394 in 2000 and an occupancy level of 137,4% (Luyt, 2019:7). The incarceration rate has since decreased to a rate of 259 per 100 000 (World Prison Brief, 2020a).

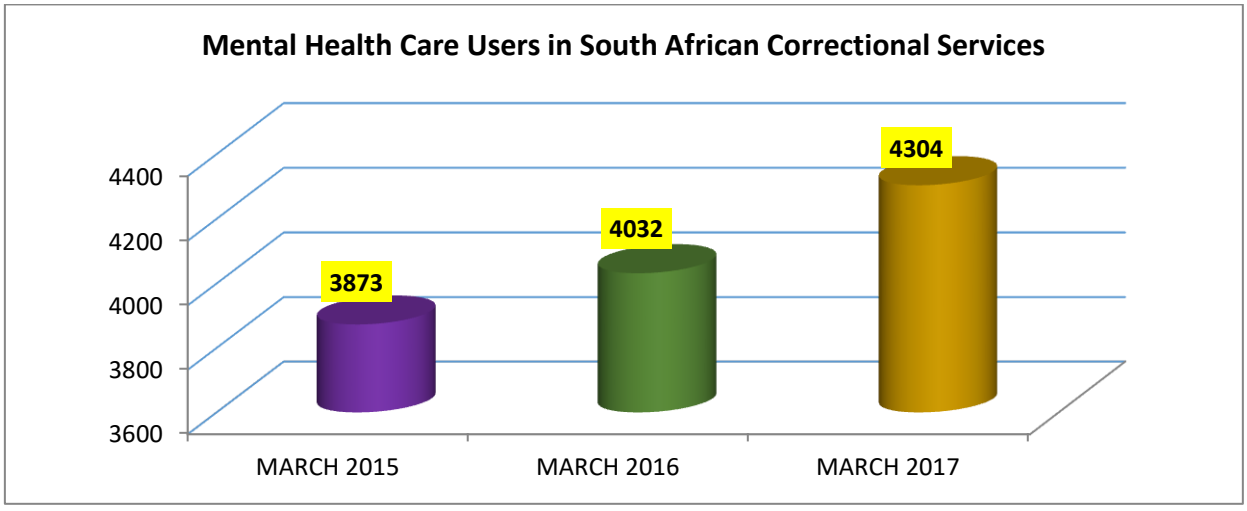
Mental health services are provided to mentally ill detainees as follows: those who are referred by the court in accordance with an order that the detainee be cared for in detention; detainees who have returned from an external psychiatric hospital to serve their sentences after being rehabilitated/recovered; state patients who should be detained temporarily in a correctional health facility; and forensic observation cases. In the case of state patients and forensic observation cases, the DCS is required to coordinate with the external psychiatric hospital within 14 days.

The percentage of involuntary mental health care users (IMHCU) is estimated to be approximately 10%-15% globally (Moosa & Jeenah, 2008:109). There are

currently no involuntary mental health care users being detained in the Department's correctional facilities (DCS Daily Unlock Total as at 31 October 2019). The Daily Unlock Total refers to the total number of inmates detained in the DCS. This figure is reported to the National Head Office and is obtained from all correctional centres on a daily basis (Department of Correctional Services, 2019a). The researcher postulates that the reason might be attributed to a circular that was sent on 16 August 2019, as an instruction to all Regional Commissioners not to admit any IMHCUs into correctional facilities. In addition, all existing IMHCUs had to be transferred to other institutions falling under the auspices of the Department of Health. The circular was sent to all regions subsequent to the gazetting of the Criminal Procedure Amendment Act No. 4 of 2017 (Department of Correctional Services, 2019b).

Figure 2 below, shows the numbers of mental health care users in the DCS over a period of three years. Mental health care users refer to all detainees who have been diagnosed with mental illness and are receiving care, treatment, and rehabilitation services but excludes observation cases. These figures in Figure 2 below included IMHCUs, as the instruction not to admit IMHCUs was only communicated in August 2019. Mental Health Care Users that are detained in DCS amounted to only 2,7% of all detainees incarcerated during the 2016/2017 financial year, i.e. 4 304 of 160 280 (Mabena, 2017).

Figure 2: Mental Health Care Users in the South African Correctional Facilities



Source: Adapted from Mabena, 2017.

Current figures on the mentally ill in DCS facilities are difficult to obtain as the only documented figures are reflected in a report by the Judicial Inspectorate of Correctional Services in their 2017/2018 Annual Report. Findings in the report, which covers visits to 81 correctional facilities conducted over a three-year period, found that 1 212 detainees were diagnosed with a mental illness (Van der Westhuizen, 2018:26-32). Of these, 157 were declared as state patients (Dano, 2018). It must be mentioned that the 81 correctional facilities visited only accounts for a third of all correctional facilities in South Africa. It is therefore safe to deduce that the prevalence of mental illness in South African facilities have increased (Dano, 2018). According to Dano (2018) there are 159 state patients in DCS facilities. This is an increase from March 2018 to November 2018.

Research, both nationally and internationally, consistently shows a high number of mentally ill persons in detention as well as increased occurrence of mental disorders among detainees (Adams & Ferrandino, 2008:913; Gowensmith & Robinson, 2017:50; Konrad & Lau, 2010:236; Naidoo & Mkhize, 2012:30). South African correctional facilities are no exception, although there is a dearth of research with regard to mentally ill detainees in South African correctional facilities.

In 2009, the first ever research study on “Psychiatric morbidity in a South African prison population” was conducted by researchers, Naidoo and Mkhize, at the Durban Westville correctional facility. The researchers established a high rate of severe psychiatric illnesses amongst detainees. The study showed that 55,4% detainees had Axis 1 disorders. Axis 1 disorders comprise psychosis, bipolar, depressive and anxiety disorders, as well as alcohol and substance use disorders. It was also found that 46,1% were identified as having an antisocial personality disorder (ASPD) (Naidoo & Mkhize, 2012:30-34). Naidoo and Mkhize (2012:33) found high comorbidity rates between Axis 1 disorders and antisocial personality disorders as indicated in Table 2 below. Major Depressive Disorder with ASPD was found to be at 30%, followed by Bipolar Mood Disorder with ASPD at 33%, Psychosis with ASPD was as high as 55% and the highest comorbidity rate with ASPD was Post-Traumatic Stress Disorder (66%). Comorbidity in this study, refers to the existence of multiple disorders in the same person, usually in relation

to an index disorder (Sartorius, 2013:69). The presence of two or more mental health disorders can lead to longer treatment times and less effective treatment (Sartorius, 2013:68).

Table 2: Comorbidity between current Axis 1 Disorders and Anti-Social Personality Disorder

Type of Axis 1 Disorders	Percentage
Psychosis with Antisocial Personality Disorder	55,5%
Major Depressive Disorder with Antisocial Personality Disorder	30,0%
Bipolar Mood Disorder with Antisocial Personality Disorder	33,3%
Post-Traumatic Stress Disorder with Antisocial Personality Disorder	63,1%

Source: Adapted from Naidoo & Mkhize, 2012:33

Further findings indicate that current mental disorders were more prevalent amongst “awaiting trial detainees”, now called remand detainees (32,8%), as compared to sentenced detainees (22,5%) (Naidoo & Mkhize, 2012:33). These figures correlate with the general South African population prevalence. Tromp, Dolley, Langanpersad and Govender (2014) quote a prevalence of 33,3% of South Africans suffering with a mental illness.

The study by Naidoo and Mkhize (2012) sets the tone for the DCS decision-makers to treat mental illnesses seriously and for DCS management to undertake initiatives to address mental health. Although a large number of detainees were found to be mentally ill, it was concerning that many more remained undetected in the system. This can be attributed to a lack of an electronic system by the DCS to capture and provide information and statistics (Makou, Skosana & Hopkins, 2018). South African Correctional Services has been accused by Motala & McQuoid-Mason (2013:40) for not providing reliable data.

Further to this, Naidoo and Mkhize (2012:35) voiced their anxiety that in the case of non-serious disorders (where urgent psychiatric attention was not needed), the detainees did not receive any form of assistance from the health care services. According to Nair (2002:2), Bertram (2020), and Nieuwoudt and Bantjes (2019:75-

77), mental health care is “virtually non-existent” in the Department of Correctional Services and therefore creates a cause for concern. Nieuwoudt and Bantjes (2019:75-77) reiterated that it was difficult and almost impossible to provide psychological interventions and ideal levels of mental care within the corrections environment. Correctional centres were furnished to treat physical and medical conditions and not psycho-social or psychiatric care.

The study conducted by Naidoo and Mkhize (2012) created an evidence base on which a comparison for future studies could be compared. Similarly, an earlier study was conducted over the period 2000 – 2004 by Barret et al (2007). This study which profiled mentally disordered detainees who were referred to the Free State Psychiatric Complex, found that the majority of the detainees suffered with schizophrenia (35.2%), and 22,5% with mental retardation (Barret et al., 2007:56). Later figures by Prinsloo and Hesselink (2014:445) confirmed that there were 1869 mentally ill detainees in the South African corrections system at the end of 2012.

The findings from another study conducted by Prinsloo (2013:133) at a Pretoria correctional centre, showed that 43,2% of the respondents were suffering with mental health illnesses. 44% of these respondents were found to suffer from schizophrenia and psychotic related disorders, and 12,1% with bipolar mood disorders, whilst 27,5% suffered with major depressive disorders. Further to this, Prinsloo (2013) found that psychopathology rates reached a high of 78,4% amid detainees with sentences 25 years and more. The actual national prevalence rates of mentally ill detainees in South African correctional systems are difficult to determine.

Evidence from the research studies discussed above, show that a large number of mentally ill detainees are being detained in South African correctional facilities. Naidoo and Mkize (2012) in their study, found that eight out of nine detainees with a psychotic disorder were not receiving treatment, and in a recent study conducted in 2019 on 14 South African corrections facilities, found that 7% of the sample of 597 detainees indicated they required mental health care (Luyt, 2019:29).

5.5.1 Sentencing in South Africa

South Africa follows general sentencing principles known as the “triad of Zinn” named after an Appellate Division decision in the 1969 case of *S v Zinn*. The “triad of Zinn” requires that, when a judge decides on sentencing, he/she reflects on the severity of the offence, the state of mind of the detainee, and the interest of the public (Goitom, 2014). The three aspects must be applied equally when considering sentencing. The trial judge has the discretionary power to decide on a suitable sentence for the crime committed, however, there are two controls on this discretionary power. The first control is that the Apellate courts can overturn sentences imposed by a trial court. The second control is minimum sentencing which is applicable to serious crimes such as “murder, rape, drug dealing, firearms smuggling, and human trafficking for sexual purpose” (Goitom, 2014).

In the case of the mentally ill, this would fall under the second leg of the triad and that is the consideration of the personal circumstances of the detainee. Sentencing would be intensified by factors such as lack of remorse, a repeat offender, amongst others. Mitigation factors would be if the offender is a first time offender, if the offender is too young or too old, as well as of diminished capacity (Goitom, 2014; Terblanche, 2013:96). Diminished capacity has been discussed in Chapter 2.

In Prinsloo’s study (2013:135), it was established that the predominance of mental illness was significantly higher for detainees who served longer sentences. 77% of detainees who suffered from some kind of mental illness were serving sentences of 20–24 years, as compared to those who were not mentally ill (33%). The findings are consistent with research conducted by Sukeri et al (2016:1). Further to this, the average duration that a mentally ill detainee spends in hospital was almost two years. It is indicated that length of hospitalisation may be related to the seriousness of the crime, such that mentally ill detainees charged with violent crimes would be hospitalised longer than those charged with less serious offences (Marais, 2014:11).

Prinsloo (2013) feels that this proves the postulation echoed by many authors, such as Fazel et al (2016:5), Johnston (2013:197-200), McNeill (2014:4205), and Van Ginneken (2016:7), that the severity of the mental state of detainees, coupled with the risk that mentally ill detainees pose to themselves and the public, plays a significant role in the determination of the kinds of sentences handed down to mentally ill detainees.

More importantly, Prinsloo found that detainees with mental disorders were more prone to criminal activities, anger, and also displayed anti-social behaviour. These pointers can be useful in the early identification and ultimate diagnosis of possible mentally ill detainees. This is also worthwhile for case management committees to consider as part of their holistic sentence-planning strategy as well as to determine suitable needs-based treatment (Prinsloo, 2013:136). Case Management Committees are "responsible for decision-making concerning the safe detention of detainees, their participation in programmes and recommendations to the parole boards on the placement or release of sentenced offenders" (Department of Correctional Services, 2010:3; Department of Correctional Services, 2011:8)

In the case of *Chauke v The State* (578/2015) [2015] ZASCA 181, the Supreme Court of Appeal of South Africa set aside the conviction and sentence of Mr Chauke who stabbed and murdered two people. Mr Chauke was found guilty and sentenced to life imprisonment for each count. The main reason for the Supreme Court of Appeal's order was that the trial judge did not possess all the relevant facts regarding the appellant's mental state. An enquiry into the mental capacity of Mr Chauke was conducted without the assistance of an expert in the field of psychiatry. This, according to the Supreme Court, resulted in a fundamental irregularity. In terms of Sections 77, 78 and 79 of the Criminal Procedure Act 51 of 1977, a court must be assisted and guided by the diagnosis of expert psychiatric evidence when an inquiry is being made into the mental state of an accused (Republic of South Africa, 1977:52-57).

Section 77(1) of the Criminal Procedure Act 51 of 1977 states that the court can order an investigation into the mental state of an accused if it suspects that the

accused is incapable of understanding the proceedings due to a mental illness. This investigation is conducted to determine whether the accused is worthy of standing trial or not (Möller, 2011:10; van der Haer, 2012:50). In Chauke's case, the trial court had doubted his capacity to understand the proceedings but failed to lodge an enquiry into his mental state.

Section 78 legislates criminal responsibility. Section 78(1) of the CPA states that no person who is suffering from a mental illness/defect shall be held criminally liable (Stuckenberg, 2016:54). Chauke's case recordings indicate that he was on medication for a psychotic disorder and schizophrenia. If this was still doubted, then an enquiry should have been ordered by the court. If it was found that Chauke did not understand the consequences of his actions nor appreciated the wrongfulness of his actions, he should have been found not criminally responsible due to mental illness and be referred to psychiatric hospital or institution in terms of s78(2).

Section 79 indicates that an enquiry must be conducted by experts in the field and the court must be assisted and guided by expert evidence. A report must be submitted in writing [s79(3)] and include a description of the nature of the enquiry and as per [s 79(4)], the report must include a diagnosis of the mental condition of the accused. In addition to this, a finding must be provided in terms of s77(1), i.e. whether Chauke understood the court proceedings in order to afford him the opportunity to make a proper defence. The report should also include a finding in terms of s78(2), i.e. his capacity to understand the wrongfulness of his actions and whether his actions at the time were affected by his mental illness. The Appellate found that the proper procedure was not followed by Dr Weiss and that he did not serve the purpose of making a finding into the mental state of Chauke.

On the issue of understanding the wrongfulness of one's action due to the mental capacity of an accused, the case of *Maluka v S* (A197/2013) [2014] ZAGPPHC 862; 2015 (2) SACR 273 (GP) has relevance. Maluka was acquitted of any wrongdoing after psychiatrists diagnosed the accused as schizophrenic and the expert evidence indicated that he was 'at the time of the alleged offence, as a consequence of a mental illness, unable to appreciate the wrongfulness of his

deeds or to act in accordance with any appreciation of wrongfulness' as expressed by s78 of the Criminal Procedure Act, 51 of 1997. He was ordered to be treated as an IMHCU at the Weskoppies psychiatric hospital.

It is evident from the cases cited, that in order for a lay court to make an inquiry into the mental state of an accused in terms of ss 77, 78 and 79, the court must be supported and guided by "expert psychiatric evidence" as indicated in *S v Mabena & another* [2006] ZASCA 178; 2007 (1) SACR 482 (SCA). An enquiry will render itself fruitless should it not be based on this expert guidance.

5.5.2 Correlates to Crime

Hendricks (2017) has asked the question, "How much crime is attributed to mental illness?", but only received an unsatisfactory, but guarded, answer from the South African Federation for Mental Health (SAFMH). The response from the SAFMH was that a profound misunderstanding exists of mentally ill people being dangerous.

Authors such as Ballard and Teasdale (2016), Naidoo and Mkhize (2012), Franklin (2014), and Gill and Murphy (2017:1) hold a strong belief that a person's mental wellbeing has a correlation with crime or persons engaging in criminal activities. Crime in South Africa results from anti-social behaviour and behaviour associated with mental disorders (Franklin, 2014:1).

Similarly, a study by Barret et al (2007), found that 77,5% of mentally ill detainees committed crimes against persons, and from this, 26,8% were accused of rape. The results from the study further showed that 33% of all property-related crimes were associated with violence (malicious damage to property); 15,5% for assault; 1.4% for "assault with intent to do grievous bodily harm"; whilst 7% of detainees committed murder. A study conducted on awaiting trial detainees sent to the Free State Psychiatric Complex for observation also yielded similar results. In this study, 98% of those found not accountable for their crime had a mental illness. The most common offences committed were assault (30,4%) and rape (21,2%) (du Plessis, du Plessis, Nel, Oosthuizen, van der Merwe, Zwiegers, & Joubert,

2017:5). Further findings of this study revealed that 94% were male, 55, 7% were unemployed, and 68% had a history of substance abuse. Of these, 8,5% suffered with substance-induced psychotic disorders. As with the study by Sirotich (2008), du Plessis et al (2012) found that persons in their late teens and early twenties suffering from mental illness are at the highest risk for violent or criminal behaviour.

Gould (2015:113), a researcher from the Institute for Security Studies (ISS), studied the relationship between crime and violence in South Africa. She interviewed detainees at the two private detention facilities, namely, Mangaung and Kutama Sinthumule, who were incarcerated for at least one violent crime. She postulates that non-clinical variables such as high levels of poverty, lack of access to quality education, and environmental factors, led to feelings of alienation and aggression. These emotions ultimately led to the disregard of authority and hence a disregard for the law. Nieuwoudt and Bantjies (2019:76) further argue that children's mentality can be shaped by a toxic environment (increased violence in the home, together with abuse resulting from one or more household members suffering from depression or substance dependency, etc). This might imply that a toxic environment shapes a child's later susceptibility to crime and violence in South Africa. Ward, Gould, Kelly and Mauff (2015:9) are in support of this statement. Their studies with children, conducted in a small settlement in the rural Western Cape, showed that parental mental health, among other factors, are meaningfully linked to a child's mental state (anxiety and depression) which they term as "children's internalising symptoms". Children and youth may find their expression in gangs and "enrol" as members of gangs. Gang members are more likely than their non-gang-affiliated individuals to engage in crime, violence, and substance abuse which increase their risk of facing the might of the law (McDaniel, 2012:253). Once incarcerated, gang affiliation, and the association with substance abuse continues. Alongside detention conditions, this contributes to mental instability and illness (Nieuwoudt & Bantjes, 2019:76).

Besides the internal risk factors, Ward et al (2015:9) found that parents' mental health and intimate partner violence is associated with the breaking of rules and

aggressive behaviour. They term this as “externalising” symptoms. This in turn would have an effect on the rest of the family members.

Naidoo and Mkhize (2012:32) found that the crimes mentally ill detainees committed ranged from violent crimes to non-violent crimes, sex crimes, and drug related offences. The violent crimes included murder, armed robbery, assault, and kidnapping, whereas the range of non-violent crimes committed by the mentally ill included crimes such as fraud, theft, and housebreaking. Sex crimes included rape and indecent assault, whilst drug related offences included possession of or dealing in illegal substances. Nearly 22% in this study were repeat offenders.

One can therefore agree that mental illness correlates highly with violent crime in South Africa, and that this correlation cannot be looked at in isolation. The literature cited indicates that the environment as well as socio-demographic factors play a huge part in increasing the risk to violence (Elbogen & Johnson, 2009; Sirotich, 2008). Similarly, one can also conclude that a link can be established between childhood development, mental illness, and violent crime.

5.6 GERMANY

Germany has 179 penal institutions. This is a decrease in the number of penal institutions from 203 in 2004 (Jehle, 2005:45). Health care is offered to its total detainee population of 59 487 as of March 2020. Statistics indicate that the detainee population has decreased in the past years on average, from 70 252 in 2000 to 59 487 in March 2020 (World Prison Brief, 2020b). Subramanian and Shames (2013:9) attribute this decrease to imprisonment being used infrequently and for shorter periods of time in Germany, whilst Jehle (2005:45) attributes these low figures to imprisonment being used as one of the last resorts of sentencing, thereby resulting in a small proportion being incarcerated in Germany. Fines and community-based sentences have resulted in low imprisonment rates in Germany (Subramanian & Shames, 2013:8). 20% of detainees consist of remand detainees (World Prison Brief, 2020b).

Germany also uses non-custodial sanctions resolutely and approaches diversion rigorously. This results in 6% of convicted detainees being sentenced to prison. In a study, authorised by the European Commission on the European Union countries and the European Free Trade Association (EFTA) countries (a total of 24 countries), Germany came out as having the 12th most detainees (Salize et al., 2007:8-15). Germany has an imprisonment rate of 71 per 100 000 in 2020, which is a decrease in the rate which stood at 85 in 2000 (World Prison Brief, 2020b).

The court in Germany, according to federal laws, decides whether a mentally ill detainee will be subjected to the prison system or the forensic psychiatric system. The court's decision is based on whether the detainee is likely to re-offend or who will take legal responsibility for the criminal act (Trestman et al., 2007:229).

There is limited data available on the mentally ill being detained in German detention facilities. Therefore, reference will be made to general psychiatric or forensic psychiatric hospitals. This information will be generalised to the detention facilties. The reason is attributed to the non-availability of registers to record information, and the fact that the German Penal Code makes provision for key data to be recorded for a fixed date in the year (Jehle, 2005:6). Thus, infrequency of readily available data and poor quality of data prevails (Zinkler & Priebe, 2002:6). Furthermore, Salize et al (2007:51) report that even though there is an upswing of mental health afflictions among the detainee population in Europe and worldwide, official and reliable data on the prevalence of psychiatric cases or the diagnoses in detention facilities are scarce. There is no information on involuntary admissions, as Germany does not keep involuntary mental health care users in prisons (Zielasek & Gaebel, 2015:14). A mentally disordered person or someone with a substance abuse dependency would in most cases, as guided by a psychiatrist's report, not be sent to detention as an involuntary admission.

Germany too is vexed by the limited research conducted on mentally ill detainees with regard to their placement and treatment in detention facilities. However, a study was commissioned from 1 October 2005 to 31 October 2007 by the European Commission. It was found that there is a decreased awareness of the needs of mentally ill detainees in corrections, that can be attributed to the

exclusion of prison mental healthcare into regular psychiatric training courses of Medical Schools or Universities (Salize et al., 2007:67).

In Germany, only two studies have explored the prevalence of mental disorders among incarcerated juveniles prior to 2009 (Köhler, Heinzen, Hinrichs & Huchzermeier, 2009:212). In the first study, which was conducted by Hinrichs in 2001 it was found that 91% juveniles suffered with a mental disorder at the time the offence was committed (Hinrichs, 2001:483). 38% were diagnosed with at least one severe personality disorder, and 25% with substance abuse/dependency (Hinrichs, 2001:482). Notably from this study, was the finding that behavioural/emotional disorders acquired from childhood and/or adolescence were found to be in the region of 16% (Hinrichs, 2001). The second study, which was conducted by Jacobs and Reinhold (2004) as cited in Köhler et al (2009:212), found that 10% - 22% of juveniles were suffering from depression with the highest diagnosis being substance-related disorders (80%). Further to this, 73% of juveniles suffered with a personality disorder. Findings of this study are criticised by Köhler et al (2009:213) for a biased sample being used. In the first study, detainees of a low security facility were used and in the second the sample was chosen from those already attending a treatment programme. Köhler et al (2009:213) maintain that although mental disorders are a major problem amongst incarcerated juveniles, dependable “prevalence rates for Germany remains unknown”. Köhler et al (2009:212) therefore found the need to conduct a study on the subject. The study was conducted on incarcerated male juveniles at the Neumünster juvenile “prison” between 2001 and 2003. Results of this study indicate that 19,5% juvenile detainees suffered a psychotic disorder, with 6,8% being a substance-induced disorder. Further to this, 81,2% had a conduct disorder, and 62,4% suffered with a personality disorder (Köhler et al., 2009:218); thereby confirming high prevalence rates of mental illness among juvenile detainees.

Salize et al (2007:158) in their study on remand detainees, found that 40% of remand detainees in Germany suffered with recurrent depressive episodes, whilst 43% had an alcohol-use disorder. In addition to this, 36% of remand detainees

were nicotine dependent, 14% were dependent on other substances (excluding alcohol), and 6% had a psychotic disorder.

According to Schildbach and Schildbach (2018:1), a type of punishment used in Germany is termed “compensation imprisonment”. It is a trans-institutionalisation process whereby a detainee is sent to “prison” to serve his sentence for not paying his/her fine. Such detainees are termed “compensation prisoners”. Mentally ill detainees who become the victims of this process end up incarcerated after being sent home from mental hospitals. A study by Schildbach and Schildbach (2018) conducted in Berlin on compensation prisoners, presented a surprisingly unreasonable prevalence of mental disorders. This study was conducted in 1999, 2004, 2010, and 2017 and showed that compensation prisoners usually are imprisoned for petty crimes and they make up 10% of the general German detainee population (Schildbach & Schildbach, 2018:1-2).

The study found, as depicted by Table 3 below, that 72,75% had fallen victim to alcohol-induced mental and behavioural disorders, whereas 50,25% had mental and behavioural ailments due to drug abuse, 35% showed signs of “phobic anxiety” maladies, 3,75% suffered with psychotic disorders (schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders), and it was revealed that 26,25% had signs of “depressive disorders”. According to Schildbach and Schildbach (2018:1-2), these figures, and findings imply that failure to pay one’s fine is a retribution of the underprivileged and mentally ill.

Table 3: Rate of mental illness amongst detainees detained in a detention facility in Berlin, Germany

Diagnosis	Diagnosis Prevalence in compensation prisoners (%)	Prevalence: General detainee population	Prevalence in general population
Mental and behavioural disorders due to use of alcohol	72,75%	21–46,7%	3–5%

Diagnosis	Diagnosis Prevalence in compensation prisoners (%)	Prevalence: General detainee population	Prevalence in general population
Mental and behavioural disorders due to drug abuse	50,25%	21–38%	9,9%
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	3,75%	0,3–3,4%	1,25–1,5%
Phobic anxiety disorders	35%	2,4–7,3% (32, 47)	6,2% (36)
Depressive disorders	26,25%	3,3–26,2%	16,8–19,2%

Source: Adapted from Schildbach & Schildbach, 2018:4

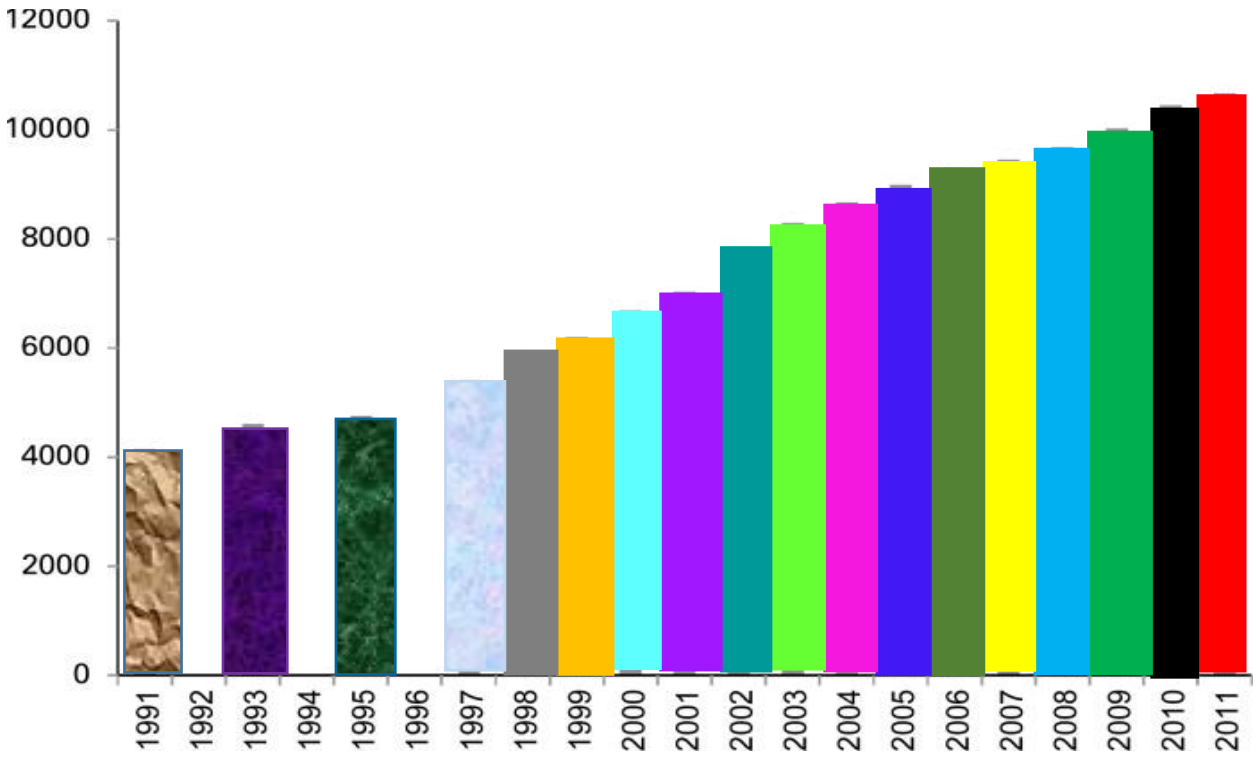
Salize et al (2007:158) indicate that the suicide rates among detainees are higher than that in the general population. This can be attributed to the high prevalence of depressive disorders among remand detainees (40%), and detainees (3,3% – 26,2%) as compared 16,8% –19,2% of that of the general population (see Table 2 for mental illness among the remand detainee population, and Table 3 for mental illness amongst detainees).

Although a large number of detainees were found to be mentally ill, it was concerning that many more remained undetected in the German prison system; and coupled with this, is the concern that these undetected cases will not receive the treatment and care they deserve (Schildbach & Schildbach, 2018:4). The reason for this, is that a system for the “surveillance” of mental illness in detention has not been developed. The data that is availed in these discussions are obtained from statistical data from various states and will be indicated as such (Lehmann, 2012:136).

The number of beds in forensic psychiatry care was 7 299 in 2003. Germany is known for having one of the largest forensic psychiatry sectors, due to the sentencing principles that focus on treatment of the mentally ill (Salize et al.,

2006:96). What is progressive with Germany, is that they embrace psychosomatic hospital treatment as a medical discipline in hospitals and rehabilitation treatment centres (Salize et al., 2006:96). Khetrapal (2018) defines psychosomatic disorder as “a condition in which a physical disease is thought to be caused or made worse by mental stress or related factors. Since this disorder correlates the mind and body, its treatment also involves remedial measures from both medical and psychological fields as opposed to only psychiatric care”.

Figure 3: Detained persons following court orders under the Federal Penal Code



Source: Salize et al, 2006:96

5.6.1 Sentencing in Germany

Germany’s inquisitorial system of criminal procedure means that evidence-taking is the primary task of the courts and not of the prosecutors and the defence attorneys. The German court makes an overall assessment of all reported incriminating and extenuating evidence, and judges consider all facts and means

of proof they find applicable to the decision (Leuschner, Rettenberger & Dessecker, 2019:3).

Judges or “judicial panels” possess the power to sentence the accused after the court has found the accused guilty (O’Connor, 2014:76-77). Sentencing options in Germany include diversions, fines, suspended sentences, and imprisonment. This therefore implies that penal sanctions are limited to day fines and imprisonment. Day fines come with a minimum of five-day fines and a maximum of 360-day fines. Sentences range from one month to fifteen years. The death penalty is obliterated (O’Connor, 2014:77). Life imprisonment is mandatory for murder, and is exclusively restricted to murder and genocide, but may be imposed for treason. The minimum period to be served before a lifer is considered for parole is stipulated to be fifteen years (Albrecht 2013:211). In other serious crimes (in particular, aggravated robbery, rape, drug trafficking, and homicide) the minimum is raised to two, three, or five years, and, in exceptional cases, to ten years. A large number of criminal cases are diverted from prosecution because many of the serious transgressions are eligible for diversion, and prosecutors in Germany have extensive jurisdiction to do this. Prosecutors can, in the case of less serious crimes (*Vergehen*), also divert through a penal order for a fine, community service, compensation, driving restrictions, mediation, forfeiture, or confiscation of assets (Subramanian & Shames, 2013:7-17).

Further to this, a court can order a parolee to undergo a “therapy order” i.e. to seek psychiatric or psychotherapeutic treatment and care at a forensic outpatient centre. Non-compliance to the therapy order can result in the detainee being sent back to serve his/her sentence in detention (Konrad & Lau, 2010:238). In some European countries, such as Austria, 100% of the time that a mentally ill detainee spends in treatment is counted towards the sentence to be served in incarceration. In Germany, however, a maximum of two-thirds of the time that the mentally ill detainee spends in treatment is counted towards the sentence (Salize & Dreßing, 2005:47).

The “day fine approach” involves fines being levied in daily units (in lieu of one day incarceration). The amount of the fine is established by considering the detainee’s

private earnings. The aforementioned is to make sure an equivalent impact is felt by transgressors who have committed equally serious crimes despite experiencing dissimilar economic conditions (Subramanian & Shames, 2013:8). The German law also offers an alternative to compensation imprisonment, which is community service. Those that are sentenced to serve compensation imprisonment can apply for serving voluntary community work instead. This, according to Schildbach and Schildbach (2018:5), is a better option, as imprisonment would further impair their poor financial status and fragile mental health.

A fairly large percentage of custodial sentences are suspended, as courts of law remain obliged to defer sentences of one year or less. Should a transgressor be sentenced to imprisonment for a period up to two years, a court will usually lay off the implementation of the judgement and refer the offender to probation, and courts are directed to suspend sentences of one year or less (Subramanian & Shames, 2013:8).

It must be mentioned that Germany has its own Juvenile Justice system. Special Juvenile courts handle juvenile criminal law cases, in line with the Juvenile Justice Act and the Juvenile Welfare Law (Pruin, 2011:1). Juveniles, according to German law, refer to persons from 14 to 17 years. Those below 14 years are children, and young adults are persons from 18 to 21 years. All persons above 21 years are regarded as adults. (Pruin, 2011:3, Jehle, 2005:8). Sanctions of the Juvenile Justice Act, include educative measures (instructions to receive socio-educational support), youth imprisonment (as a last resort) with or without suspension, and disciplinary measures. Educative and disciplinary measures can be imposed simultaneously (Jehle, 2005:35). The aim of a disciplinary measure is that the offender "must be made acutely aware that he/she must assume responsibility for the wrong he/she has done" as indicated in s13 of the Juvenile Justice Act. Disciplinary measures take the form of reprimands, reparation, to apologise personally to the victim, to perform certain tasks, or to pay a sum of money to a charitable organisation (Pruin, 2011:6). The Juvenile Court can also send the juvenile to a special juvenile detention centre ("Jugendarrest") for one or two weekends, or for up to four weeks (Pruin, 2011:3). Due to the dearth of

statistics in Germany, information will be provided on juveniles if available and will be specified as such. If it is not specified, then the figures include all detainees.

Further to this, juveniles that were subjected to the Juvenile Justice system were 149 415. Of these, 47 853 cases were dropped/terminated by the Public Prosecution Office in accordance with Section 45(3) and Section 47 of the Juvenile Court Act of 1923. The total convictions amounted to 101 562, and of these, 77 273 detainees were sanctioned with a disciplinary measure, and 7 001 (4,7%) were subjected to an educative measure (Jehle, 2005:37). Just over 17 000 were sentenced to youth imprisonment. Of these, 6 646 (4,4%) were imprisoned without the sentence being suspended, and 10 642 (7,1%) were sent for imprisonment, with the sentence being suspended. The most frequent sanction imposed on juveniles is disciplinary measures (51,7%) (Jehle, 2005:37).

Table 4 provides an overview of the sanctions imposed both for adults and juveniles in West Germany and Berlin. Adults who were sentenced under general criminal law in 2003 were 634 735. 80% of these were sentenced to a fine (507 086 cases). Roughly two-thirds, 14% (88 043) of the 127 511 prison sentences resulted in the person receiving a suspended sentence and being placed on probation. Six percent (39 468) were sent to detention without suspension.

Sanctions for both adults and juveniles obtained for former West Germany and Berlin in March 2003 are depicted in Table 3. Note that figures for the whole of Germany which included adults and juveniles were not available.

Table 4: Sanctions for adults and juveniles obtained for former West Germany and Berlin in March 2003

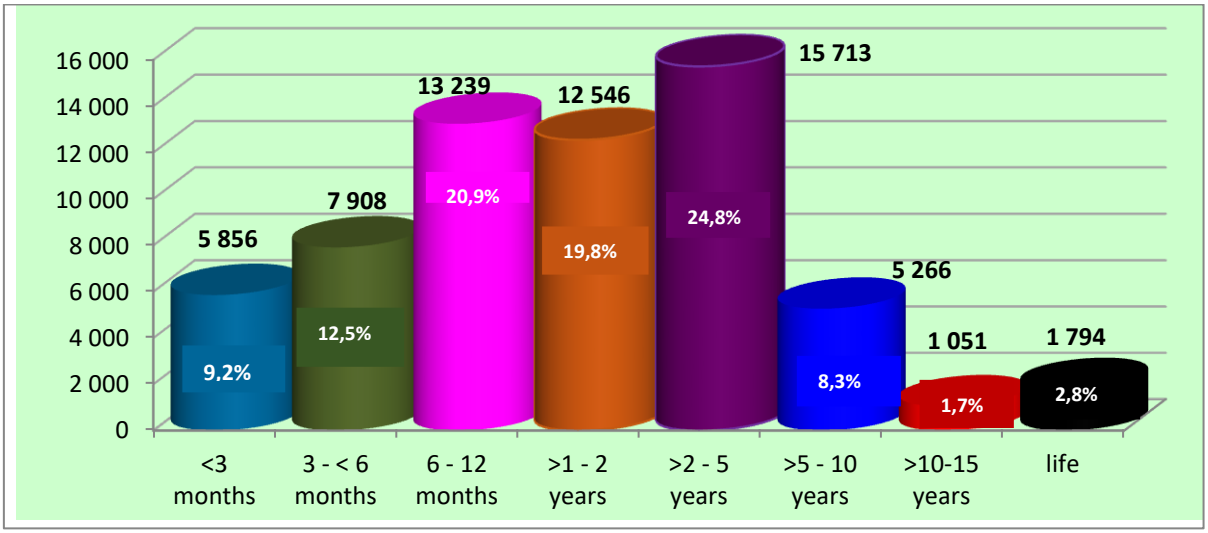
ADULTS	**Total**	**Percentage**
Fine	507 086	80%
Imprisonment – not suspended	39 468	6%
Imprisonment – suspended on probation	88 043	14%
Total	634 597	100%
JUVENILES	**Total**	**Percentage**
Disciplinary measures	77 273	52%

Educative Measures	7 001	5%
Youth Imprisonment – not suspended	6 646	4%
Youth Imprisonment – suspended on probation	10 642	7%
Termination	47 853	32%
Total	149 415	100%

Source: Adapted from Jehle,2005:31

The length of imprisonment in Germany is determined by the length time spent in remand subtracted from the sentence imposed (Jehle, 2005:49). The data from the figure below shows that 42,6% of detainees spend a year or less in detention and as much as 22% spend less than six months. Nearly 13% will spend more than five years whilst only 2,8% will serve a sentence of life imprisonment (Jehle, 2005:50). Similarly, 54,1% juveniles spend a year or less in detention, 34,4% between one and two years. Nearly 11% of the juveniles will spend between two and five years, and 0.6 % between five and ten years (Jehle, 2005:37).

Figure 4: Length of detention of those detained in corrections as at 31 March 2004



Source: Adapted from Jehle, 2005:50

Mentally disordered detainees will either be given life sentences (only those who committed murder), be placed in preventive detention, or be given hospital orders (detention in a psychiatric hospital or detoxification clinic), as sanction by German courts. Both preventative detention and hospital orders are regarded as indefinite

preventive measures (Drenkhahn, 2013:312). The European Council for Human Rights states that individuals who have been released from preventive detention could be institutionalised in a secured treatment unit if they suffer from a mental disorder. An assessment will be conducted every 18 months for treatment purposes (Basdekis-Jozsa et al., 2013:346).

Preventive detention, as discussed in earlier chapters, refers to placing the detainee in a prison after punishment has been served. Punishment and preventive detention are both part of a sentencing decision at the end of a trial and may be ordered by either the criminal or civil courts. For purposes of this discussion, the researcher will focus on sentencing decisions made by the criminal courts. Mentally disordered detainees can also be given hospital orders combined with a prison sentence if diminished criminal responsibility is proven, but only if the detainee is regarded as dangerous (Jehle, 2005:34). Dessecker (2009) indicates that most of these will probably not end up in incarceration. Time spent in preventive detention and in hospitals (by way of a hospital order) is indefinite and has no fixed term. Preventive detention is used as a method of preventing the detainee from committing any imminent harm to the community. It must therefore not be seen as a punishment for the crime committed (Allen & Laudan, 2011:782).

Jehle (2005:34) points out that there are other sentencing options available to those accused whose culpability is diminished. These options can, according to German law, be imposed separately to the main sanction and are not dependent on the main punishment. The law regarding mental treatment of detainees changed in 1998. All detainees with a personality disorder, which falls within the definition of the mentally ill, had to be treated in social therapeutic units in the prison system. The law also required that sex offenders sentenced to longer than two years had to be committed to a social therapeutic unit (Trestman et al., 2007:231). The numbers of detainees at social therapeutic units increased to such an extent that some detention facilities could not cope. An example of this, is the Hessen Prison Social Therapeutic Unit. Of the 2 165 detainees that were sentenced to more than two years in 2005, 1 829 suffered some kind of personality disorder. This posed a challenge, as only 140 beds were available (Trestman et al., 2007:232).

The 2003 conviction statistics for other imposed sanctions are shown in Table 5 below. Besides a fine or imprisonment, there is also the possibility of a driving ban as "ancillary punishment" (Jehle, 2005:8). Interventions to either reform a detainee or to safeguard the community include committal to a psychiatric hospital or to an institution for withdrawal treatment. In 2003, 876 mentally disturbed detainees were committed to a psychiatric hospital. The driving ban (a short-term measure) is the second highest sanction applied. The most common is the withdrawal of permission to drive either temporarily or permanently. It aims to remove unbecoming drivers off the road for a substantial period of time. Preventive detention (post imprisonment) for the mentally ill was only enforced in 66 cases.

Table 5: Other measures and additional sanctions - Former West Germany and Berlin

	Total Crimes	Excluding motoring offences
Driving ban	32 737	5 456
Forfeiture, confiscation	18 092	17 300
Measures to reform detainee / protect public		
Withdrawal of permission to drive	125 998	9 045
Committal to psychiatric hospital	876	866
Committal to institution for withdrawal treatment	1 643	1 554
Preventive detention (post imprisonment)	66	66
Ban on occupation and supervision of conduct	196	188

Source: Jehle, 2005:35

Statistics provided by Dessecker (2009) indicate that prior to 1997 there were, on average, only 36 preventive cases, and this figure increased to 64–66 in the period 1997 to 2006. There was a significant increase in the numbers of mentally ill detainees in preventive detention, as the March 2008 figures show 435 detainees in preventive detention, and figures for 2011 indicate that 500 detainees

were in preventive detention (Basdekis-Jozsa et al., 2013:344). The length of detention in a psychiatric hospital or one in preventive detention varies between federal states of Germany.

5.6.2 Correlates to Crime

Crimes in Germany are categorised into two groups, namely, the “Vergehen”, which refer to petty crimes, and “Verbrechen”, for severe offences whose punishment is that of a minimum sentence of one year. Minor crimes definitions differ from one country to another. In Germany, it includes moderately serious to highly serious crimes, many of which would be considered as serious crimes in South Africa, and as “felonies” in the United States (US). These are crimes that include “burglary, forgery, extortion and aggravated assault” (Subramanian & Shames, 2013:6).

As discussed, assault is one of the crimes regarded as a serious crime in Germany. According to Dessecker (2009), there were 500 – 600 cases of detainees given hospital orders annually, due to the routine declarations from experts, labelling many detainees who committed petty crimes as mentally disordered or psychopathic. These numbers decreased after 1965, due to the inability to treat such detainees effectively, and the widespread awareness and debates on lengths of confinements. In 2007, mental hospital statistics show over 6 000 detainees were accommodated in West Germany, with an average length of stay of five years nine months. The increase in hospital orders could be attributed to what Dessecker terms the “psychiatrisation of crime problems” and/or the hype that manifested around sexual offences. During 2003 and 2004, approximately 20% of individuals accused of sexual offences were given hospital orders. In 2005 and 2006, it was 17% and 12% respectively. Further to this, Dessecker (2009) rationalises the growing importance of hospital orders. The call for more punitive sanctions resulted in the change in crime demographics, with a large percentage (37%) of all hospital orders being assault cases.

To strengthen the argument that mentally ill persons commit violent crime, Basdekis-Jozsa et al (2013:354) found in their study, that 82,8% suffered with Axis

1 disorder, whilst 81 % suffered from an antisocial personality disorder. Further to this, three fifths of detainees were detained for one or more sexual offence. This study was conducted at the state-run detention facilities at Luebeck, (a federal state of Bavaria) on detainees in preventative detention during the period 2009 till 2012.

The risk factors of violent crimes are fortified in German law (Elbogen & Johnson, 2009; Corrigan & Watson, 2005; Sirotich, 2008). The fact that German Law permits the ordering of parolees not to drink alcoholic beverages, is indicative of the lawmakers believing that committing crime and violence is related to substance abuse (Konrad & Lau, 2010:238). According to Schildbach and Schildbach (2018:1), in their investigation on compensation prisoners, the majority of compensation prisoners were dispossessed, unemployed, presented a high degree of substance abuse, and they showed an exceptionally high prevalence of mental disorders. In addition to the mentioned risk factors, compensation prisoners suffer with comorbid mental illness such as co-occurring anti-social personality disorder (Lehmann, 2012:134). One-third of the mentally disordered detainees who were issued with a hospital order to the Haina Forensic Psychiatric Hospital (Hessen State) had been diagnosed with a personality disorder. Moreover, an additional 25% of patients had a co-occurring anti-social personality disorder which, according to Trestman et al (2007:231), increases the risk of a mentally ill person's exposure to violence and crime. In a study by Opitz-Welke and Konrad (2012:241) at the Berlin Prison hospital, it was found that 24,3% had additional diagnoses of antisocial personality disorder.

It is believed that detainees with a primary or secondary personality disorder have a history of psychiatric problems, and a long history of difficulties with the law. This in effect means that they are at a high risk of recidivism (Trestman et al., 2007:231). An investigation by Siefert and Möller-Mussavi (2005:16), into the recidivism rates of 255 mentally ill detainees indicated a recidivism rate of 21,6%, of which 7,5% reoffended with seriously violent or sexual offences. This concurs with research that mental illness has a correlation with violent crime (Winstone, 2016:90). Compensation prisoners spend on average two to three months in detention (Schildbach & Schildbach 2018:1). Because of the short periods spent

in detention, there is little or no opportunity to learn new trades or skills, and the cycle of poverty continues once they return to the community. High recidivism rates lead to more detainees being admitted than those being released. Schildbach and Schildbach (2018:3) raise concerns that the number of compensation prisoners increased by 18,4% between 2009 and 2017, although detainees in Germany decreased by 9,1% from 2009 to 2017. They ascribe this to the decreased ability of many detainees to pay their fines. This in turn, is indicative of their low economic status.

Seidel, Konrad, Negatsch, Dezsö, Kogan, Gauger, Neumann, Voulgaris and Opitz-Welke (2019) in a case-controlled study, studied patients at a psychiatric ward of the Berlin Prison Hospital over two periods, i.e. from 1997 – 2006 and then again from 2010 – 2016. It was found that more mentally ill patients were admitted for violent crimes in 2016 (15,9%) than in 2010 (3,2%). This alludes to the fact that mentally ill detainees are being sentenced for more serious crime rather than petty crimes. Of all detainees that displayed violent behaviour in the prison hospital, only 6,1% were diagnosed with schizophrenia, as opposed to 18% in 2016. Although there was an increase in schizophrenia, there was no evidence of increased violence in the prison hospital (Seidel et al., 2019:5), yet Opitz-Welke and Konrad (2012) in their study, found that 17,8% of mentally ill patients displayed suicidal and / or violent behaviour during detention and therefore had to be restrained.

Seidel et al (2019:5) as well as Opitz-Welke and Konrad (2012:242) did not find a correlation between violent behaviour and age in their respective studies. This is contrary to other researchers' findings (Jehle, 2005; Sirotich, 2008; Stevens, 2013), as well as international literature which points to young age being a risk factor for violent behaviour in psychiatric patients.

Contrary to literature, which suggests that prior arrests, prior convictions, and dubious criminal behaviour in the past is a risk factor for future behaviour (Sirotich, 2008:174), the study conducted by Seidel et al (2019:4-5) found that there were more patients without a previous sentence in the violent group than in the non-violent group.

The debate around the “assimilation”/prisonisation of detainees has been on the forefront of many, and it is believed that prolonged detention can lead to depression, personality disorder, and increased aggressive behaviour, therefore unnecessary prolonged detention must be avoided (Dettbarn, 2012:236). In the case of *K v. Germany*, K was sentenced to three years imprisonment for repeated rape, two counts of attempted rape and violence on three women. The court found him to have “acted with diminished criminal responsibility” and he was convicted to two years and six months for dangerous assault. Whilst in the psychiatric hospital, he committed four counts of rape, sexual assault, attempted rape and urinated on five prostitutes. In 1992, he was ordered by the court to serve his sentence before he continued his stint in the psychiatric hospital. He denied guilt and refused therapy and therefore was transferred to the Schwalmstadt Prison and served his full sentence. In 1995, he was then ordered by the court to be detained in a psychiatric hospital for crimes committed in 1987. He was sent back to the prison in 2007 because a second expert found him not to suffer from a serious personality disorder or that he acted with diminished criminal responsibility. He was released on 8 January 2008 but sent back to prison for harassing a woman and her partner. In 2012, the applicant then filed this case whilst still serving his sentence. The court ruled in his favour and cited that according to Article 67d (6) of the Criminal Code, that K’s being sent to prison as “preventative detention” should not have taken place and that he should have been released. The court also ruled that the reconsidered order for the applicant’s preventive detention constituted an additional penalty which prolonged his detention which is in contravention of Article 7(1) of the European Convention on Human Rights (Council of Europe, 2012:2-23).

In conclusion, it is evident that the association between poverty and mental illness is significant, and at the same time, the mentally ill who are not rehabilitated but released from detention are prone to poverty. Lack of community support and discontinuity with medication may lead to further severity of the diagnosed mental illness. Although studies in Germany focus on specific states, it can be deduced that adverse life events and substance abuse are risk factors that can lead to mental illness and are trigger factors to violence and crime.

5.7 NIGERIA

Nigeria has the largest population in Africa with an approximated population of 197 530 000 as on 31 March 2018 (Central Intelligence Agency, [sa]). According to Yusuf and Nuhu (2009:231), an estimated 70% of Nigerians do not have access to mental health amenities. In addition, most mental health facilities are positioned in urban areas, which make accessibility difficult for the majority of the population.

Nigeria has 240 detention facilities to serve its population. This number has remained the same since 2014. Yet, the detainee population has increased with an average of 74,6% from 40 953 in 2006 to 61 802 as at July 2020. Of these, 73% are remand detainees (United States Department of State 2017c:7; World Prison Brief, 2020c). Overall, Africa has an increased detainee population of 50,91%. Nigeria is ranked 26th in the world for countries with the most incarcerated persons (Olagunju et al., 2018:80). Nigeria's imprisonment rate increased from 29 in 2006 to 30 per 100 000 in 2020 (World Prison Brief, 2020c).

Stephens (2018:230) has reported that Nigeria makes fewer efforts to provide mental health services to their detainees, even though health care is supposed to be offered to its total detainee population.

International research into the predicaments surrounding mental illnesses in the corrections environment show that mental illness is higher in detention facilities than the general population (Fazel et al., 2016:871). This statement is supported by researchers such as Olagunju et al (2018:80) who indicate that 60% of detainees suffer with psychiatric disorders. This percentage is far higher than that of the general population which has a 12% prevalence. Further to this, there are larger numbers of severely mentally ill persons in Nigerian detention facilities than in psychiatric hospitals, because corrections authorities are mandated to care for detainees who suffer with a mental disorder in accordance with Section 7 of the Prison Act, 1972 (Federal Republic of Nigeria, 1972; Ogunlesi & Ogunwale, 2018:36). Detainees who suffer with a mental ailment are given treatment in Nigerian detention facilities even when found 'not guilty by reason of insanity' as

indicated in s230 of the Criminal Procedure Act (Federal Republic of Nigeria, 2004).

Lovett, Kwon, Kidia, Machando, Crooks, Fricchione, Thornicroft and Jack (2019) pointed out that research on the problem of mental disorders in the criminal justice systems of Africa is sparse. Further to this, very few large-scale studies have been conducted on the mentally ill in Nigerian detention facilities. The literature reviewed indicates various studies have been conducted, but they are very marginal and were conducted at specific locations, and therefore make it difficult to generalise the findings. However, the studies cited do give an idea of the prevalence rates of mental illness as well as issues faced by mentally ill detainees within the incarcerated population in Nigeria. One of the reasons for this dearth of information is that the majority (approximately 70%) of mental health services are provided by religious groups and traditional healers (Ayonrinde, Gureje & Lawal, 2004:537). Services through such means are not properly documented and not made available internationally (Ayonrinde et al., 2004:537).

Although much has been written on the state of mental illness in Nigeria, statistical information on the mentally ill in detention facilities remain scarce. Information and statistics are not easily available as manual systems are kept, although the corrections authorities are gradually computerising their systems (Obioha, 2011:103). In a study done by Amnesty International in 2008 it was found that three out of ten corrections facilities had no medical facility (Obioha, 2011:107). The situation remained stagnant in 2012 (Stephens, 2018:230). The United States Department of States (2017c:9) reported that although efforts were made to establish mental health facilities, most facilities did not offer the mental health care required. Agboola, Babalola and Udofia (2017:10-11) conducted a research study to determine the prevalence of psychopathology among 278 detainees (162 males awaiting trial and 106 convicted detainees) in Calabar prison, located in the South geopolitical zone of Nigeria. The researchers found that 22% had anxiety and depressive disorders ranging from general to severe and most of the detainees were regular visitors to the prison clinic for physical treatment (receiving medical treatment for body weakness, recurrent headache, and internal heat) instead of psychiatric evaluation and treatment. The results from their study also showed that

5,2% suffered with a schizophrenic illness and only 33,3% had been assessed and were receiving treatment from the visiting psychiatrist. The researchers concluded that there was a high occurrence of psychiatric illness in detention facilities (49%). The most common was a “depressive episode” (32,8%), yet only 15,8% of the depressive cases were referred to the visiting psychiatrists from the Federal Psychiatric Hospital in Calabar (Agboola et al., 2017:12).

In a study conducted by Abdulmalik et al (2014:193-199), among 725 awaiting trial males, it was established that the prevalence rate of mental illness was 56,6%. The most common mental illness was depression at 20,8%, alcohol and substance dependence at 40,7%, suicidal tendencies at 19,8% and “antisocial personality disorder” was at 18%. The researchers further add that these rates do not differ significantly from those of sentenced detainees.

Another study carried out among detainees at a medium security facility in Ilesa in southwestern Nigeria between the period January and March 2006, it was found that those diagnosed with mental illness did not suffer with mental illness before their imprisonment (Fatoye, Fatoye, Oyebanji & Ogunro, 2006:549). It was also found that the extent of detainees with imminent medically diagnosable psychiatric morbidity was as high as 87,8%, and those with substantial depressive symptoms were 85,3%. These were fairly high, and are similar to the high rates observed among detainees in developing countries (Fatoye et al., 2006:551). Other variables with significant relationships with depressive symptoms included being poor, having a low-level education, being a Muslim or traditional worshipper, and being unmarried, divorced, or separated (Fatoye et al., 2006:545).

An interesting study that focused on the clinical documents and forensic assessment reports of patients referred by the CJS to the Katsina State Psychiatric Hospital in Northern Nigeria over a period of two years, found that 64,8% were diagnosed with schizophrenia. Schizophrenia, substance use and “organic” mental disorders were conveyed to be the typically reported diagnoses among mentally ill detainees (Yusuf & Nuhu, 2009:231). Organic mental ailments refers to a condition where the brain disorder is the main cause of the mental illness (Goldstein, 2001:443).

From the above studies, it can be deduced that a large percentage of Nigeria's detainee population suffers from mental illnesses.

5.7.1 Sentencing in Nigeria

Sentencing options provided by Nigerian law include the death penalty, imprisonment, fines, caning/haddi lashing, forfeiture, deportation, probation/suspended sentence, community work, and plea bargain. Offences which bear a death sentence include the "abatement of suicide of a child or insane person" amongst others (Oraegbunam, Ozioko, & Osim, 2019:34). Northern Nigeria has also expanded capital offences to embrace adultery, sodomy, lesbianism, and rape for which the death sentence is a mandatory punishment (Idem & Udofia, 2018:4). There still remains much contention on the two sets of law regarding pregnant women receiving the death penalty in Nigeria (Okakpu, 2017:40). According to s368(2) of the Criminal Procedure Act of 1990, pregnant women are let off from the death sentence but are given life imprisonment instead (Federal Republic of Nigeria, 2004:82). However, the enactment of the Administration of Criminal Justice Act of 2015 radically changed the above. Section 404 of the Administration of Criminal Justice Act of 2015 provides that a pregnant woman found guilty of a capital offence can still be given the death penalty, but its implementation is suspended until the baby is delivered and weaned (Okakpu, 2017:39). The death penalty cannot be given to children and young detainees (Oraegbunam et al., 2019:34). A juvenile justice system is also in existence in Nigeria to attend to children's and young detainees' matters. There are no significant provisions for juvenile detainees in Nigeria, despite the existence of the Children and Young Persons Law of 1958 and the Child Rights Act of 2003. Such legislation tends to be ignored as juvenile detainees are in most cases, accommodated with adult detainees (Ajah & Ugwuoke, 2018:438) and many are languishing in Nigerian detention facilities (Amnesty International, 2008b:34). A "child" is defined as a person under the age of 14, while a "young person" is defined as a person who has attained the age of 14 and is under the age of 18 (Obidimma, & Obidimma, 2012:84).

Caning or Haddi-lashing aims to shame the suspect instead of actual punishment and mainly applies to Muslim men in the Northern States. Women and persons over 45 years are exempted from haddi-lashing, and in Eastern Nigeria, only those from the age group 18 to 21 years can be beaten using a cane (Idem & Udofia, 2018:4).

When sentencing, courts can use their discretion for mitigation of sentencing. The factors taken into consideration include the age and gender of the accused, whether it is a first offence, as well as having a mental illness, amongst others. However, there are certain limitations to this. These limitations include mandatory sentences, such as the death sentence for treason, murder, and armed robbery. Another limitation is that of minimum and maximum sentencing (Oraegbunam et al., 2019:38).

The length of detention for those suffering from mental disorders ranges from one year to over ten years in forensic inpatient units (World Health Organization, 2006:17). Forensic inpatient units refer to secured units in a psychiatric institution that accommodates clients living with mental illness, who have been in conflict with the law (convicted or not) (Seppänen, Törmänen, Shaw and Kennedy, 2018:1). They are admitted through an order issued by the court, either for assessment or for treatment and care. The World Health Organisation reported that no patient spends less than a year in mental facilities, 9% of mentally ill spend one to four years, 23% of them are detained for five to ten years, and 68% for more than ten years in forensic inpatient units. A dismal number of beds (0.08 per 100,000 population) are made available in the forensic inpatient units for the mentally disordered. This is supported in a study by Abdulmalik et al (2014) on 725 awaiting trial detainees of Agodi Prison, Ibadan, between December 2012 and February 2013. It was found that 40% of the respondents spent more than one year in detention awaiting trial.

Caring for a mentally ill family member is very costly, and families prefer to hand over such responsibility to corrections so much so that they are willing to fabricate a case against the mentally ill family member – usually citing a breakdown in family relations (Westbrook, 2011:398). Amnesty International (2008b:37), in their

interview of involuntary mental health care users (IMHCUs) at a Nigerian "prison", concluded that the voices of one of four mentally ill IMHCU is not heard in Nigerian courts. The courts may even decide on matters in the absence of the mentally ill. All the court needed was someone to testify that the mentally ill person is violent (Westbrook, 2011:398). This is reason enough for courts to then send the accused to the asylum (usually a prison) for medical observation. It is said that such persons usually stay in these "asylums" for long periods, or may not even leave the asylum. Amnesty International (2008b:37) cited a case where a woman spent 18 years for not even committing a crime but was placed in prison by her family who did not want to care for her (Amnesty International, 2008b:37).

According to Chukwuemeka (2010:114-115), Nigeria has an average awaiting trial population of 69%, and at some facilities the population of awaiting trials are as high as 98%. Some detainees are said to be awaiting trial for up to ten years. Nnam (2016:181) attributes these long periods awaiting trial to the inability to pay for the services of a lawyer, corruption in the system, and other "bureaucratic processes". Nigeria's criminal law by default allows for the prolonged imprisonment of the "not guilty by reason of insanity". Nigeria's "failing justice system" results in these remanded detainees being accommodated indefinitely in corrections (Chukwuemeka, 2010:114-115; Nnam, 2016:181; Ogunlesi & Ogunwale, 2018:37).

One in ten Nigerians believe that mental illness is a punishment by God, whilst 30% believed that mentally ill people were possessed by evil spirits, thus resulting in the mentally ill being ostracised and denied even basic social contact (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005:440). This "spirituo-magical" concept of mental illness as indicated by Lasebikan (2016:325), stigmatises mental illness, thus resulting in persons in detention not reporting their mental illnesses to the authorities. This may imply that medical care would not reach such individuals. Even those already on treatment may not take their medication as prescribed as they would be more likely to seek assistance and treatment from spiritualists and traditional healers. This would jeopardise their chances for consideration of release thus having to spend longer time in detention.

5.7.2 Correlates to Crime

Mentally ill detainees are said to have committed serious crimes and are subsequently viewed as violent (Corrigan & Watson, 2005:153; Lawal, Mosaku, Ola & Morakinyo, 2014:535; Rosen & Teasdale, 2016:1). Several studies show various correlates to violent crimes such as demographic, contextual, clinical and socio-economic background, amongst others. Very few studies in Nigeria, show that mentally ill detainees commit less serious crimes. Amnesty International (2008b:18) conducted a study in July 2007 in the Federal Capital Territory (FCT) and Enugu, Lagos, and Kano States. They found both criminal "lunatics" and civil "lunatics" being accommodated in the same cell. They found that only three of four men of the 92 criminal "lunatics" had committed serious crime. They also found that a third of the "civil lunatics" had committed no crime and were admitted to corrections merely because their family could not cope with the responsibility of caring for them (Amnesty International, 2008b:37-38). Instead of receiving treatment at hospitals or mental health institutions, these "civil lunatics" are jailed in asylums within detention facilities where they do not receive any treatment (Westbrook, 2011:398).

Table 6 gives an indication of the top four offences for each crime category for 2017 as well as the national total of offences. Offences against persons contribute to 40% of all crimes committed. Further to this, rape and indecent assault, murder, assault, and "grievous harm wounding" accounts for 75,9% of all offences against persons. Almost 50% of offences against property are theft and stealing (32 348), whereas almost 76% of crimes against lawful authority are "breach of peace". Trends indicate that theft/stealing is the highest crime committed in Nigeria. According to the National Bureau of Statistics, theft/stealing accounted for over 24% of all crimes committed from 2014 to 2017 (National Bureau of Statistics, 2020b).

It must be noted that several authors (Oueslati, Fekih-Romdhane, Mrabet & Ridha, 2018; Yusuf & Nuhu, 2009) use homicide instead of murder as a crime, which is different to that in the National Bureau of Statistics. For purposes of this discussion, the crimes will be named as they appear in the documents used.

Table 6: Snapshot of crimes committed nationally: Nigeria, 2017

Crime Categories		
Offences Against Property		Total
Theft /Stealing	32 348	**68 579**
False Pretence & Cheating/ Fraud	11 779	
House Breaking (3212)/Burglary (2167)	5 379	
Armed Robbery	3 527	
Other	15 546	
Offences Against Persons		
Assault	24 025	**53 641**
Grievous Harm Wounding	11 191	
Murder	3 219	
Rape and indecent assault	2 279	
Other	12 927	
Offences Against Lawful Authority		
Breach of Peace	9 605	**12 443**
Gambling	471	
Escape from Custody	123	
Forgery of Currency	111	
Other	2133	
National Grand Total		**134 663**

Source: Adapted from National Bureau of Statistics, 2020a.

Oueslati et al (2018) conducted a case-controlled study at the forensic psychiatry unit in Razi Hospital over a period of 24 years from 1 January 1985 to 31 December 2014. This study focused on patients who re-offended and those who did not re-offend. Table 7 below depicts the crimes committed by both the groups. Arson, damage to property, and theft are not regarded as violent crimes by the researchers. The crimes that were committed most by these patients were homicide (36% of the re-offenders and 42% of non-re-offenders). This was followed by arson (16% of re-offenders and 18% of non-re-offenders). Rape was committed by 4% of re-offenders and by 3% of those that did not re-offend.

It was found that 72% of re-offenders committed violent crimes on admission (18 of the 25 that re-offended). Similarly, 77% of the non-re-offenders had committed violent crimes on admission. The re-offence was violent in 64% of the cases (Oueslati et al., 2018:180). Other findings of this research support the views of authors such as Sirotich (2008) and Elbogen and Johnson (2009) on the factors that increase the risk for mentally ill detainees committing crime. Poor

neighbourhoods are said to have high crime rates, which increase the risk of the detainees associating with criminal peers, thus increasing their risk of involvement in criminal activities (Oueslati et al., 2018:181). 68% of mentally ill detainees that re-offended came from a poor neighbourhood, and 62% of mentally ill detainees in this study were found to have “pro-criminal companions”.

Behavioural and emotional disorders with onset in childhood or adolescence were also strongly correlated with offending (Stevens, 2013:2675). 64% of mentally ill patients suffered some sort of behavioural and emotional deprivation during their childhood, 80% came from broken homes, 76% mentally ill detainees lacked parental guidance when growing up, and a third had early delinquency problems (Oueslati et al., 2018:180-182). It can therefore be deduced from this study that socio-economic and psychosocial conditions in childhood are strongly associated with offending.

Further to this, this study revealed that 84% mentally ill re-offenders were single, 56% were unemployed, 76% were young (below the age of 30), and 40% had a low level of education (less than 5,5 years of schooling). These results are similar to those of a study conducted by Yusuf and Nuhu (2009:231) who concluded that the majority of mentally ill patients are young, unemployed, single, and without formal education.

Yusuf and Nuhu (2009:231) found in their study at the Katsina State Psychiatric Hospital in Northern Nigeria, that homicide (the equivalent to murder) was the most common crime committed by mentally ill patients. It was also found that homicides constituted 68,4% of all the offences, and 64,8% of the patients were diagnosed with schizophrenia. Having reviewed the clinical records and forensic assessment reports over a two-year period, it was indicated that other variables such as poverty and educational levels, were determinants of a balanced mental state. Where one lived also played an important role in the state of mind of a person. Findings included that 73,7% of those that committed homicide were living in a rural area, whilst 68,4% did not attend any formal education.

Table 7: Types of crimes committed by re-offenders and non-re-offenders

Note: Violent crimes are homicide, attempted homicide, rape, rape attempt, and other physical assaults.

Offence type	Re-Offenders				Non Re-offenders	
	Index Offence		Second Offence (re-offence)			
	n	%	n	%	n	%
Homicide	9	36%	2	8%	16	42%
Homicide attempt	3	12%	7	28%	6	16%
Rape	1	4%	0	0%	1	3%
Rape attempt	2	8%	1	4%	2	5%
Other Physical Assaults	3	12%	6	24%	4	11%
Arson	4	16%	2	8%	7	18%
Damage to property	2	8%	3	12%	2	5%
Theft	1	4%	4	16%	0	0%
Total	25	100%	25	100%	38	100%

Source: Oueslati et al., 2018:180

Mafullul, Ogunlesi and Sijuwola (2001) studied the psychiatric records of accused persons in a Nigerian facility, who were referred for evaluation prior to trial. Findings were that 68% of the accused had killed victims which resulted from some form of psychotic motive (Lovett et al., 2019:10). The court also acknowledged that psychotic behaviour and alcohol intoxication had accounted for the homicide transgressions of 24% of the accused.

Violent crimes have been associated with mental disorders (Lawal et al., 2014:536). Ayuba, Audu, Choji and Mela (2004:211) in their study of 12 500 detainees who were ordered by court to undergo psychiatric evaluation, found that only 1,3% had committed homicide and that the rate of mental disorder was 16,5%. 49% were diagnosed with schizophrenia, 29,4% had major depressive

disorder, and 7,84% were suffering from bipolar disorder. Further to this, 35,3% of those with mental disorders had been attended to by a psychiatrist (Ayuba et al., 2004:212).

From the literature studied, it is evident that in Nigeria, seriously mentally ill detainees are at a higher risk of committing violent crime. Predictors of crime include dependence on or abuse of substances. In addition to this, studies show that mentally ill detainees commit crime at a young age and this could be attributed to their childhood/upbringing and/or the neighbourhood that they come from. Poverty compounds mental ill-health and this plays a role in determining the increased risk of committing crime.

5.8 UNITED STATES OF AMERICA (USA)

In addition to the criminal court system which punishes adult detainees, the USA has a juvenile court system which governs detainees under the age of 18. All 50 states also have legal mechanisms to try juveniles as adults in criminal courts (Human Rights Watch, 2019:622; Washburn, Teplin, Voss, Simon, Abram & McClelland, 2008:1). The juvenile system was initially established in the 1800s for the treatment and rehabilitation of juveniles in the best interest of the juvenile (Urban, Cyr & Decker, 2003:456). The juvenile system recognised that children do not have the same moral capacity as adults (Chhabra, 2017:2). With the increase of youth crime, the juvenile system shifted its focus in the 1960s to that of punishment, with the aim of holding the individual accountable for his/her actions. Determinate sentencing and the consequential longer lengths of sentences for juveniles was introduced. At the same time, public mental health services for children decreased, and this averted youths into the criminal justice system. This resulted in greater numbers of adolescent detainees being handled in the adult criminal justice system (Chhabra, 2017:2). These cases are transferred to the adult criminal justice system through a judicial waiver, an automatic transfer, and through prosecutorial direct file. In a judicial waiver, the juvenile court judges make decisions on a case-by-case basis, considering the characteristics of the charge. An automatic transfer is based solely on the type of offence, criminal history, and the age of the juvenile. Judges are not involved in this form of

transfer. A prosecutorial direct file is determined by the prosecutor, as they are allowed to file juvenile cases directly in criminal court (Washburn et al., 2008:1-2). The information provided in this study includes both adults and juveniles tried in the adult criminal justice system. Where statistics are made available for juveniles only, it will be indicated as such.

The term incarceration is used interchangeably with imprisonment when discussing the USA. The USA system that incarcerates detainees is referred to as the Corrections system.

The Corrections system in the USA consists of “local counties or municipal corrections agencies”, 50 state systems and a federal system. The USA has 4 455 detention establishments. These are made up of 3 163 local jails, 1 190 state facilities, and 102 federal prisons (Walmsley, 2019a). Jails are locally operated and are administered by local law enforcement agencies. They usually detain individuals awaiting trial or those awaiting sentencing, as well as detainees who have been sentenced for less than a year for a misdemeanour (Carson, 2020:2). Prisons, on the other hand, are long term facilities that are run by a state or the federal government and are used to accommodate detainees serving sentences for more than a year. Federal prisons detain individuals charged with federal felonies (Brooks, 2019). Felonies are defined as “the most serious crimes you can commit”. Some examples of felonies include murder, drug trafficking, identity theft, tax fraud, rape, burglary, kidnapping, child molestation (FindLaw, 2019a).

Federal prisons are under the jurisdiction of the Federal Bureau of Prisoners (BOP), a subsidiary of the Department of Justice (Carson, 2020:2). Detainees held in federal prisons have been charged with federal crimes, such as drug trafficking, identity theft, tax fraud, or child pornography (Brooks, 2019). Federal prisons prohibit parole, so the amount of time served is significantly higher than the average time served in a state detention facilityprison. State prisoners, on the other hand, accommodate detainees who have committed state crimes, such as assault, arson, robbery, or homicide. Each state has its own prison system, and each state determines how its correctional system functions (Brooks, 2019).

Of the world's detainee population, United States (US) detainees account for the largest imprisoned population in the world (Olagunju et al., 2018:80). Statistics indicate that the detainee population has decreased from 2 217 000 as at 31 October 2015, to 2 121 600 as at 30 September 2018, and remand detainees consist of 23,4% of all detainees. Despite this 4% decrease in the detainee population, the USA still incarcerates the most detainees in the world, and has the highest incarceration rate globally (Walmsley, 2019a). Similarly, although there was a decrease in the incarceration rate from 698 in 2015 to 655 in 2018, it still remains the highest rate globally.

US detention facilities progressively detain mentally ill detainees, and it is estimated that every 6th US detainee suffers from a mental disorder. This amounts to an estimate of 300 000 to 400 000. The number of mentally ill detainees currently outstrips the number of mentally ill patients in other institutions, thereby making the US Corrections system the foremost supplier of mental health services (Gonzalez & Connell, 2014:2328; Heines, 2005:1687; Turner, 2008:415). More than 16% of all US detainees are seriously mentally ill (Gowensmith & Robinson, 2017:50). According to the National Institute of Mental Health (2019), the USA general population shows that a staggering 34,2% of the general population from the age of 13 and older suffer with a mental illness. Further to this, Golembeski and Fullilove (2005:1701) maintain that the incidence of severe mental disorders, is two to four times greater amongst detainees as compared to that of the overall population. These mental disorders include schizophrenia, major depression, bipolar disorder, and posttraumatic stress disorder. Heines (2005:1685) estimates it to be three to five times higher. No matter the actual estimates, it is a high substantiation that is supported by many authors (Gonzalez & Connell, 2014:2328; Rich, Chandler, Williams, Dumont, Wang, Taxman, Allen, Clarke, Greifinger, Wildeman, Osher, Rosenberg, Haney, Mauer & Western, 2014:3; Gill & Murphy, 2017:1; Tamburello & Ferguson, 2016:29). Heines (2005:1685) attributes this to the under-funding of the USA's mental institutions, no access to treatment, or a lack of available treatment, for mentally ill detainees as well as a high non-compliance rate for the provision of medical care in the community structures. This leads to a higher-than-average rate of imprisonment for mentally ill detainees, since imprisonment paves a way

for receiving the necessary medical intervention for a severe mental illness as guaranteed by the US Constitution (Tamburello & Ferguson, 2016:29). However, the reality is, that the imprisoned in the USA do not have access to medical aid or medical care (Rich et al., 2014:3).

The deinstitutionalisation of the mentally ill from state hospitals resulted in a decrease in the number of patients being treated at state hospitals. Prior to the process of deinstitutionalisation, 560 000 people with psychopathological disorders were in state hospitals. Currently, there are less than 40 000 (Heines, 2005:1687). Whilst the numbers of mentally ill decreased at state hospitals, it increased in prisons in the USA. Kliewer, McNally & Trippany (2009:40) indicate that this is so because communities were not fully resourced nor equipped to accept the mentally ill at community care centres. This resulted in numerous severely mentally ill persons not receiving the necessary treatment and care, leading to an increase in violent episodes and their subsequent incarceration (Kofman, 2012:33-39).

Aalsma et al (2015: 1372) further indicated that about 60% to 80% of imprisoned youth are inflicted with at least one mental disorder. Binswanger, Merrill, Krueger, White, Booth and Elmore (2010:476) also explored the gender differences of psychiatric disorders among those detained in jails nationally. Weighted estimates were calculated for psychiatric disorders, specifically for depressive, psychotic, posttraumatic stress, personality, bipolar, and anxiety. Women in US “jails” documented a substantively greater burden of chronic medical and psychiatric maladies than men in jails (67,3%) as can be noted in Table 8 below. This information is confirmed by the Bureau of Justice (Bronson & Berzofsky, 2017). 66% of detainees were recorded to have a history of mental illness and 68% of females had a history of mental illness. According to Binswanger et al (2010:476), women in the general population report a higher prevalence of depression and anxiety than men. Detainees held in jails in the USA also report a higher proportion of depression and anxiety among women (54%) than men (23,5%), as is clear in Table 8. Although less men (52,7%) abused or were dependent on drugs as compared to women (59,3), more men (24,6%) abused alcohol than women (18%). Addiction to drugs and alcohol did not account for gender

differences in chronic medical or psychiatric conditions (Binswanger et al., 2010:479).

Table 8: Rate of male and female inmates who have reported Psychiatric Disorders, Drug Abuse or Dependence, and Alcohol Abuse, Survey of Inmates in Local Jails, 2002

Psychiatric disorder	Men, Weighted %	Women, Weighted %
Depressive	17,4	35,5
Bipolar	8,7	20,7
Psychotic.	4,4	6,0
Post-traumatic stress	4,4	11,3
Other anxiety	6,1	18,5
Personality	4,7	8,7
Any psychiatric	21,6	43,6
Drug abuse or dependence	52,7	59,3
Alcohol abuse	24,6	18,0

Source: Binswanger et al., 2010:479

A study was conducted by Gonzalez and Connor (2014), who used data obtained from 18 185 detainees interviewed in the “2004 Survey of Inmates”. The survey was administered in state and federal prisons. This study found that 28,4% of state detainees and 19,12% from the federal prisons suffered with a mental disorder.

Table 9 below provides a breakdown of the mental illnesses most suffered by detainees. Depression (30,12%) was the most prevalent mental health condition reported, followed by mania (13,88%), and anxiety (11,77%). Mental health conditions were reported more frequently among detainees in state institutions. Further to this, it was found that only 52,47% of federal detainees, and 42,22% of state detainees received medication whilst in incarceration (Gonzalez & Connell, 2014:2331).

Table 9: "2004 Survey of Inmates" in State and Federal detention facilities, United States showing the prevalence of mental health conditions among detainees

Mental Disorder	State detainees *n=14 499*	Federal Detainees *n=3 686*
Reported at least 1 mental disorder in their lifetime	27,09%	17.56%
Depression	19,2%	10,92%
Mania	9,77%	4,11%
Anxiety	7,13%	4,64%
Posttraumatic stress disorder	5,72%	3,16%
Personality disorders	6,04%	3,28%
Schizophrenia	4,65%	1,98%
Other mental illness	0,81%	1,96%
Detainees receiving medication	42,22%	52,47%

Source: Adapted from Gonzalez & Connoell, 2014

Further to this, statistics from the Department of Justice in the USA were made available in a special report on the indicators of mental health problems. These statistics were based on a survey conducted from January 2011 to February 2012 on inmates incarcerated in American jails and prisons. When comparing the results of the 2004 survey to the 2011-2012 survey in Table 10 below, it can be deduced that mental illness amongst inmates has increased over this period. 40 – 44% of inmates had a history of mental problems, and 24,2% to 30,6% suffered with a major depressive disorder. High rates of bipolar disorders were prevalent amongst prisoners (17,5%), and jail inmates (24,9%). Those that suffered serious psychological distress were in the range of 14,5% to 26,4%.

Table 10: Mental health among prisoners and jail inmates, 2011-2012

Mental Disorder	Prisoners n = 1 441 800	Jail inmates n = 720 200
History of a mental health problem	36,9%	44,3%
Major Depressive disorder	24,2%	30,6%
Bipolar disorder	17,5%	24,9%
Schizophrenia	8,7%	11,7%
Post traumatic stress disorder	12,5%	15,9%
Anxiety	11,7%	18,4%
Personality disorders	13%	13,5%
Serious Psychological distress	14,5%	26,4%

Source: Adapted from the Bureau of Justice Statistics, National inmate Survey, 2011-2012

The prevalence of mental health disorders in the juvenile justice system in the USA is more than three times higher than in the general youth population (Hyde, 2016). According to Tennyson (2004:258), between 50% and 75% of detained juveniles in the USA have a "diagnosable" mental disorder, and this figure may be as high as 95% if it includes substance abuse. Of this, 20% suffer severe mental health problems, which limit their ability to function in daily life (Hyde, 2016). A similar prevalence of mental illness amongst juveniles was found in Cook County, Illinois. 66% of males and 74% of females detained had a mental disorder (Chhabra, 2017:2; Underwood & Washington, 2016:3). These figures show that females in the juvenile justice system are predominantly vulnerable, making them more likely than their male counterparts to suffer from these disorders, often at a more extreme level (Hyde, 2016).

5.8.1 Sentencing in the United States of America

The composition of the US CJS is multidimensional, and it differs from state to state (Lekalakala, 2016:83). Likewise, sentencing and punishments also vary, however the structures for sentencing are supplied by the Federal Government which determines minimum and maximum punitive measures (O'Connor,

2014:78). Federal sentencing guidelines which were dispensed by the United States Sentencing Commission (initiated by the Federal Government) serve as a guide to states to standardise, regulate, and develop, their own policies for sentencing (Lekalakala, 2016:83).

Sentencing is done by a judge and is based on factors that include a previous criminal record, character of the accused, the age of the accused, and whether the accused has any criminal history. The judge also considers other circumstances around the case as well as whether the crime was conducted under duress/coercion/provocation, or whether the accused was the main perpetrator or an accessory (someone who assists the main accused) (FindLaw, 2019b). These are by no means the only factors considered by the judge.

The issue in all types of sentencing of the mentally ill detainee, be it a capital or non-capital crime, is the role mental disorder should play both in mitigation or in aggravation of sentencing. A judge, upon sentencing an accused, will invariably be mindful of the state of mind of the accused, and may consider the risks that imprisonment poses to a detainee's mental vulnerability. However, a tailor-made sentencing package that considers the effects of incarceration on the state of mind of a mentally ill person may not always be possible. This is because not all states consider the susceptibility to harm in incarceration as an extenuating factor in their legal sentencing models (Johnston, 2013:152). The Kansas state does not recognise that mental illness is a defence which can acquit a defendant on the basis that his illness prevented him/her from identifying his/her criminal act as morally wrong. A defendant can raise mental illness to show that he/she lacked the required intent for a crime. He/she can also raise mental illness in mitigation of sentencing. In *Kahler v. Kansas*, the State of Kansas found James Kahler guilty of murder and sentenced him to death at the end of August 2011, after he shot and killed four family members. The prosecution's psychiatrist conceded that Kahler indeed suffered from clinical depression but argued that he was still capable of planning the murders. On appeal to the US Supreme Court, Kahler argued that the prosecution violated his right to a fair trial, as they did not consider his insanity defence in mitigation of sentencing. The US Supreme court upheld the verdict of the Kansas Supreme Court that the due process clause in the

Fourteenth Amendment does not compel the acquittal of any defendant who, because of mental illness, could not tell right from wrong when committing his crime (LexisNexis, 2020b).

States that do not consider all mitigating factors in a case can be found to be in violation of the Constitution, as in the case of *Lockett v. Ohio*, 438 U.S. 586 (1978). Sandra Lockett, the driver of the getaway car for a robbery that resulted in the murder of a pawnshop owner, was found guilty under the Ohio statute, and sentenced to death. No other mitigating factors were considered. The Eighth and Fourteenth Amendments of the US Constitution required, in all but the rarest cases, that sentencers consider all mitigating factors surrounding the accused murderer before coming to the decision of applying the death penalty. These mitigating factors include, "a defendant's character or record and any circumstances of the offense submitted as a reason for a sentence less than death." On appeal, the Supreme Court held that the Ohio statute violated the Eighth and Fourteenth Amendments in failing to give the sentencing judge a full opportunity to consider all mitigating factors surrounding the alleged murderer before coming to the decision to apply the death penalty (LexisNexis, 2020a). The Ohio law required that the death penalty was mandatory for detainees convicted of aggravated murder, unless the victim had induced the offense, the offense was committed under duress or coercion, or the offense was a product of mental deficiencies.

Nearly every crime in the USA can lead to a conviction except for public order crimes (O'Connor, 2014:78). The system in the USA appears to be all about criminality and severe punishment resulting in the unreasonably long sentences given to detainees (Jenkins, 2016).

In the case of *Atkins v. Virginia,* the U.S. Supreme Court proclaimed that the capital punishment of persons with mental illness amounts to harsh and inhumane sanctioning and is therefore unlawful under the Eighth Amendment of the American Constitution (Garrett, Jakubow & Desai, 2017:609; Morse, 2011:942). This has set the precedence for future cases.

Although incarcerated mentally ill detainees are often deprived of appropriate mental health treatment, it is speculated that they stay longer in detention and are less likely to be considered for early release (Gill & Murphy, 2017:1). Mentally ill individuals who are arrested by the police would be detained in jails eight times longer than those without mental illness (Heines, 2005:1687). Draine, Wilson, Metraux, Hadley and Evans (2010:458), in an attempt to determine whether persons diagnosed with mental illnesses spent longer jail terms, studied the prison records and mental health records from a Medicaid databank for all detainees admitted into the Philadelphia system in 2003. The researchers found that 1 457 detainees suffered with severe mental illness, and of these, more than 50% were discharged within a month of imprisonment. They concluded that mental ailment status was not linked to lengthier detention. It was also established that 49% were released by way of applicable random release instruments which included bail, releases from court, or recalling of a warrant.

In 2003, in the landmark case of *Oregon Advocacy Center v. Mink*, the Ninth Circuit Court of Appeals ruled in favour of arrestees with a mental illness who waited long periods in detention. The ruling stated that mentally ill persons were not to be held in detention for more than seven days after being found to "not have the mental capacity to stand trial" or the state psychiatric hospital would be in violation of the Fourteenth Amendment's "ban on deprivation of liberty without due process". Yet, according to Tullis (2019), arrestees with a mental illness continue to be detained for more than seven days. Tullis (2019) reports that in 2017 eight USA states reported having average waiting times of longer than 35 days to be evaluated for competency in 2017. In addition, 11 states reported average wait times exceeding 28 days before transferring people from jails after they were found incompetent to stand trial. In 2014, thirty-one states had no space for new detainees because the need for inpatient services was rising. California, in 2015, recorded one defendant who had waited 258 days for bed space at the state hospital. Alarming to note, is that Texas, in 2018, recorded an average period of 229 days being held in detention (Tullis, 2019). It is unacceptable that mentally ill detainees are detained for such long periods in detention.

Statistics released by the Bureau of Justice Statistics (Bronson & Berzofsky, 2017:6) show that at least 17,4% of seriously mentally ill detainees were given a life sentence. It can be deduced from the Table 11 below that sentencing is harsher for detainees who have a history of mental health problems. 37% to 45% of inmates were given a sentence of five years or more and 39% were sentenced to life.

Table 11: Length of sentence of mentally ill prisoners and jail inmates

Offence and time served	Serious psychological distress		History of a mental health problem	
Sentence Length	Prisoners	Jail inmates	Prisoners	Jail inmates
Less than 1 year	14,9%	22.5%	35,7%	42,9%
1- 4 years	13%	22,4%	35,9%	45,6%
5 years or more	14,5%	25,3%	37,3%	44,7%
Life sentence	17,4%	No information	38,9%	No information

Source: Adapted from the Bureau of Justice Statistics, National inmate Survey, 2011-2012

It is clear that various studies have produced different arguments on whether the mentally ill are detained longer in correctional facilities. However, there is more literature that proves mentally ill are detained for long periods in detention. Mentally ill persons do not belong in detention, not in corrections detention facilities, nor in psychiatric prison hospitals. It is also widespread knowledge that psychiatric prison hospitals are costly, they do not have the necessary resources, they are expensive to run, and they are not appropriate to provide for detainees with mental illness (Daniel, 2007:409; Tullis, 2019; World Health Organization, 2005). Prevailing conditions in detention worsen mental disorders, as detainees have poor access to mental health treatment which in turn translates to a violation of their human rights. The afore-mentioned are sufficient reasons for the mentally ill to be released as early as possible. They must be treated and cared for by the nation's health system, but only if adequate treatment and rehabilitation services are well established in the community/Department of Health (Daniel, 2007:406).

5.8.2 Correlates to Crime

Gill and Murphy (2017:1) postulate two reasons why the mentally ill are more prone to end up incarcerated. They refer firstly, to the "criminalization" of the mentally ill which are also called clinical factors and are said to be directly related to criminal behaviour. Secondly, Gill and Murphy (2017:1) refer to the criminogenic factors that contribute to increased inclinations to participate in criminal behaviour. Criminogenic factors are also called non-clinical factors (Gill & Murphy, 2017:2).

The criminalisation of the mentally ill resulted from the process of deinstitutionalisation. Proper community-based treatment could not be dispensed to the mentally ill, as deinstitutionalisation was not accompanied by sufficient funding (Gill & Murphy, 2017:1). This lack of resources and decreased accessibility to hospitalisation meant that the mentally ill could not be properly treated. Vallas (2016:1) is resolute in saying that when the mentally ill show signs of mental behaviour, they are unable to understand the wrongfulness of their actions resulting in them being scooped up into the CJS, even though they may be detained for minor transgressions such as sleeping on the sidewalk. A concept referred to by Hatcher et al (2009:7) as "mercy-booking".

Further to this, Gill and Murphy (2017:2) claim that mental illness conditions are unmistakeably associated with illegal behaviour. Clinical factors such as diagnosis, symptoms of mental illness, and non-adherence to medication-taking have been found to be reasons for the mentally ill to display behaviour that will warrant an arrest. Ghiasi and Singh (2019) attest to the statement by indicating that some psychiatric conditions escalate a person's possibility of transgressing the law, such as those who persistently experience delusions, or have prolonged paranoia. This can pose a major problem for the corrections health system in the USA, as only 54,3% of prisoners and 35% jail inmates who suffered a mental illness received mental health treatment since their admission (Bronson & Berzofsky, 2017:8).

Researchers have indicated that mentally ill detainees suffering from schizophrenia are violent (Binswanger et al., 2010:449). This, according to Ghiasi and Singh (2019), is certainly true, but only if they do not receive adequate and timeous treatment for their mental illnesses. Between 10% and 20% of criminal behaviour among people with a mental illness is to a certain extent related to illness symptoms (Gill & Murphy, 2017:2). In corroboration with the overall belief that those with a serious dysfunctional mental illness are a risk to others, Varshney et al (2016:223) nevertheless state that they make up a trifling segment of violent detainees. The Bureau of Justice Statistics survey released by the US Department of States in 2017, shows that 14% of prisoners and 10% of jail inmates with serious psychological distress were charged with assault within 30 days of the survey (Bronson & Berzofsky, 2017:9). According to Table 12 below, violent crimes ranged from 16,6% to 29,2% among those that suffered serious psychological distress and from 41,7% to 47,9% of those who had a history of mental illness. Contrary to this, Hatcher et al (2009:7) indicate that the majority of the detainees in USA prisoners and jails who are inflicted with a mental disorder are non-violent, low-level infringement lawbreakers who repeatedly rotate through the CJS. 24% to 48% were arrested for drug and alcohol related offences. This is so, because of their substance abuse, and lack of access to mental health and social services within communities (Adams & Ferrandino, 2008:913). The mentally ill in the USA, according to Long (2014), are incarcerated for as much as five times longer than those without a mental illness.

Table 12: Crime correlates of mentally ill prisoners and jail inmates

Offence and time served	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
Most serious offence				
Violent	16,6%	29,2%	41,7%	47,9%
Property	15,6%	27,1%	41,4%	49,8%
Drug	10,2%	24,6%	26,8%	38,8%
DWI/DUI	14%	23,5%	32,4%	37,9%
Other public	13,2%	25,9%	35,6%	45,4%

Offence and time served	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
order				
Gender				
Male	14%	25,5%	34,8%	40,8%
Female	20,5%	32,3%	65,8%	67,9%
Assaults whilst incarcerated	14,2%	9,7%	11,6%	9,9%
Criminal History				
1 time	12,1%	23,4%	27%	30,8%
2 – 3 times	13,5%	23,8%	32%	36,7%
4 – 10 times	14,6%	23,2%	39,6%	46,7%
11 times or more	18,1%	25,3%	48,9%	55,9%

Source: Adapted from the Bureau of Justice Statistics, National inmate Survey, 2011-2012

"Criminogenic" factors or non-clinical risk factors, including factors such as previous criminal records, substance dependence and misuse, antisocial traits, psychosocial factors, and socio-demographic variables, amongst others, are prognostic of criminal and violent behaviour (Gill & Murphy, 2017:2). Nearly a quarter of jail inmates and 18% of prisoners with a mental health problem, had served 11 or more prior incarcerations – as depicted in Table 12 (Bronson & Berzofsky, 2017:7). Similarly Boots and Wareham (2011:84) in their study on the mentally ill in Chicago, found that family and peers have an influence on youth violence and offending decisions among the mentally ill. Inmates aged 24 years and younger, had the highest rate of mental illness (63% among state prisoners and 70% for jail inmates). Affective disorder (a form of clinical depression) is found in about 10% to 25% of incarcerated youth. Youth with affective (mood) disorders, conduct disorders, and attention deficit hyperactivity disorder (ADHD), have an increased tendency toward anger, irritability, and hostility which will increase the possibility that they will incite angry responses from others. This would enhance the risk of actions that may accelerate to physical violence and result in arrests (Grisso, 2008:145).

Heines (2005:20) agrees with this, and strengthens the argument that there is indeed a connection between those with mental illness and their circumstances. Mentally ill individuals usually come from troubled, unstable backgrounds, where drugs and sexual abuse contribute to the mental health of an individual. On average, 75% of mentally ill prisoners in the USA met the criteria for substance abuse or substance dependence (James & Glaze, 2006:1). According to Grisso (2008:146), substance use disorders were found in 40% to 50% of incarcerated youth. The statistics illustrate further the relation between substance use disorders and delinquent behaviour which, if untreated, exacerbates aggression as they transition into adulthood (Grisso, 2008:146).

James and Glaze (2006:1) found that twice as many state detainees with a mental problem were homeless in the year before their arrest, as compared to those without a mental problem. Further to this, they found that jail inmates were three times likelier to have reported being physically or sexually abused in the past.

Mentally ill detainees also suffer violent victimisation in detention. The prevalence rate of such victimisation ranges between 7,1% and 56% among young detainees (Varshney et al., 2016:223. Blitz, Wolff and Shi (2008), in their study on state and federal detainees, found that physical victimisation (inmate-on-inmate) for males with a mental disorder was 1,6 times higher than that of males with no mental disorder. It was also found that physical victimisation (staff-on-inmate) for males with any mental disorder was 1,2 times higher. Similarly, female detainees with mental disorders were 1,7 times more likely to report being physically victimised by another detainee than did their counterparts with no mental disorder. Mental illness with comorbid substance abuse and poverty were found to be the risk factors for victimisation which in turn creates a relationship between victimisation and violent behaviour by patients with severe mental illness (Vallas, 2016:6; Varshney et al., 2016:223). Comorbidity refers to the presence of two or more disorders (Cuncic, 2020), i.e. when a person suffers with a principal ailment, and has an added medical condition.

5.9 CONCLUSION

The literature clearly supports the substantiation that the prevalence of mental illness among the incarcerated is greater than the general population.

In addition, it is clearly evident that there is a general agreement on the interrelatedness of mental illness to the risk for committing violent acts. The relationship confirms that not only are those who are mentally ill run the risk of being victimised by the CJS, but also increases the risk to commit violent crimes or to be victimised. Researchers have indicated that there is no unconditional consensus reached on the "specific psychopathology and symptoms" that culminate in violence (Biswas et al., 2018; Sirotich, 2008; Underwood & Washington, 2016). However, the literature reviewed above for all four countries shows that succumbing to violence is often manifested through exposure to risk factors such multiple substance abuse/misuse, non-compliance or non-continuance of medication, a history of aggression and violence, criminal history, underprivileged background, and exposure to unsavoury neighbourhoods.

CHAPTER 6

MENTAL HEALTH SERVICES IN CORRECTIONS

6.1 INTRODUCTION

Detainees often come from communities that lack access to mental health services (Durcan & Zwemstra, 2014:87). Even though they represent a very small percentage of the world's total population (0,13%), they are likely to be extensive users of health services, including mental health services (Armiya'u, Obembe, Audu & Afolaranmi, 2013:12). Literature has shown that detainees have high rates of psychiatric disorders in both developed and developing countries, and in some countries, there are more people with severe mental illness in detention than in the communities (Durcan & Zwemstra, 2014:88; Fazel et al., 2016:2).

In this chapter the researcher outlines the process from admission to considerations for release of the detainee, as it relates to screening, assessment, and attendance at treatment and care programmes. It is also important to discuss rehabilitation programmes and services for mentally ill detainees in each country, as well as the conditions under which these occur within the corrections systems. This knowledge is imperative so that the corrections systems can plan for an intensive and integrated service that will make it easier for the detainee to adapt to the community upon release, as well as for the treating and continued treatment of the mental condition (Rössler, 2006:151).

In the past, patients suffering from both psychotic and non-psychotic disorders were identified for psychiatric rehabilitation even though the majority of acutely mentally ill are those diagnosed with schizophrenic disorders. Today, international guidelines, such as the Mandela Rules and the United Nations Principles for the Protection of Persons with Mental illness, and the Improvement of Mental Health Care, amongst others, require that all persons suffering from grave and persistent mental illness are provided with the necessary treatment and care services. The purpose of rehabilitation is to take an individual to a level where he/she can function within the ambits of the disability (mental or physical) (Rössler, 2006:151).

That is to say, that the mentally ill must be provided with the tools to improve their "emotional, social and intellectual skills" required to "live, learn and work" as members of the community without having to depend entirely on professional support (Rössler, 2006:151).

The theoretical framework under which all four countries being studied conforms to, is the "Rehabilitation Theory of Penology" which has its origins in Lombroso`s biological school of criminology. It deduces that criminals are sick individuals who must be "cured" or "treated by reforming them", so they can function as corrected and better people after their imprisonment (Edafe, 2019:94). Criminologists became aware that punishment on its own was not preventing an offender from committing crime, and therefore crime could not be controlled. Therefore, certain rehabilitative and reformative techniques such as probation and parole were introduced to help change the people's attitude toward the criminal. What was also considered is detention under humane conditions (Edafe, 2019:94). Earliest rehabilitation theorists were John Howard (1726-1790) and Samuel Romilly (1757-1818). Alexander Maconochie, an Australian, and John Augustus, an American, developed the framework for parole and probation as reformative treatment strategies which emphasised reform and correction of the detainees rather than punishment (Edafe, 2019:94). The renaming of "prisoners" to "corrections" conveys an intent to assist and support the offender and correct his/her criminal behaviour (Department of Correctional Services, 2005). Rehabilitation programmes are planned or specifically undertaken (Stephen & Dudafa, 2016:2). Utilising educational programmes, faith-based programmes, drug treatment programmes, anger management programmes, and many others, are all aimed at helping the detainee "get better" so that his/her threat to the community is diminished. There are two intervention strategies which provide the framework within which rehabilitators must work. These strategies are aimed towards the rehabilitation of patients, including detainees. The first, is "individual-centred" and is directed towards strengthening a mentally ill person's abilities in interacting with stressful surroundings. The second, is guided towards the manipulation of possible stress- inducing stimuli in the environment. The majority of physically and mentally ill persons require a mix of both approaches (Rössler, 2006:152).

Correctional systems must provide an environment where detainees can be made to understand their crime and the seriousness of the criminal act as well as its effect on their victims, families, and communities. The purpose of forensic psychiatric observation is to determine/assess whether or not an accused has a mental illness, and to come to a decision as to whether the accused is competent to stand trial, and whether they are criminally responsible (Marais & Subramaney, 2005:3).

Rehabilitative efforts must culminate in the detainee coming to terms with the wrongfulness of his/her act/s, and the acquisition of skills that will empower the detainee to reintegrate into society upon release (Olonisakin, Ogunleye & Adebayo, 2017:36).

It therefore stands to reason that specialist personnel will be required to ensure that mentally ill persons reach this functional goal. There are many challenges that any correctional system would encounter in the process of reaching this functional goal, from the moment the mentally ill detainee enters the correctional system to release. In many instances, such specialist staff is not available or not employed in the respective department of corrections or the relevant CJS. This requires collaboration among judiciary, corrections, the department of health, and in some instances, the embassies (in the case of foreign detainees), to provide health care to detainees (Salize et al., 2007:17). If health care services are run by the judiciary, and not the countries' health care services, it may lead to inefficiencies in service provision. This may even result in corrections administrations dispensing treatment favouring safety aspects at the expense of health care requirements. On the other hand, if health care is solely run by the care system this could cause bureaucracy challenges (Salize et al., 2007:18). Government cannot solely provide health services, especially mental health services, as it simply cannot afford the high rates of specialist staff such as psychiatrists. Thus, there is a need for an integrated collaborative effort by government and other community stakeholders to ensure that holistic rehabilitation/reform, therapeutic and specialised services is provided to detainees. In order to obtain a holistic picture of the management of mentally ill detainees, it is just as imperative to highlight the influence that members of the

multidisciplinary teams have on the detainees' rehabilitation path. Correction systems around the world face a myriad of challenges that impede the implementation of rehabilitation programmes.

The daily operations and reforms of the corrections system are negatively affected by the lack of responsiveness and support from major role-players. The challenge of finding effective ways to practically apply international guidelines, standards, and norms is exacerbated by the lack of interest shown towards the corrections systems. Corrections is at the end of the value chain, and time and again the most neglected institution by government (Griffiths, 2013).

Among the most serious difficulties faced by corrections are overcrowded correctional centres. Overcrowding destabilises and relentlessly restricts reform programmes and generates many added challenges that impact on the development and rehabilitation efforts of the Department of Corrections (Griffiths, 2013). Various categories of detainees, such as those with differing crime histories, cohabit in the same cells due to overcrowding (Stephen & Dudafa, 2016:1). This could lead to "crime contamination", where the detainee who has committed minor crime learns to become a hardened criminal.

In addition, those with differing health statuses who are accommodated together run the risk of acquiring comorbidities and ultimately leading to an increase in the prevalence of communicable diseases such as tuberculosis, hepatitis B and C, and HIV/AIDS that, in turn, place severe demands on the corrections health care system (Griffiths, 2013). Adding to the already burdened prison health system is the COVID-19 pandemic (Beaudry, Zhong, Whiting, Javid, Frater, & Fazel, 2020:1).

Corrections all over the world cite scarce resources (human, budgets, facilities), and overcrowded correctional facilities add to the burdens of corrections. The standard of health care and treatment offered in correctional facilities depends on the amount of finances apportioned for this function (Salize et al., 2007:27). The increase in the detainee population means an increase in costs incurred by the corrections system for health care of detainees. The onset of the COVID-19

pandemic has resulted in a global economic breakdown which has increased the risk to developing mental health problems and in the worsening of health inequalities (Moreno, Wykes, Galderisi, Nordentoft, Crossley, Jones, Cannon, Correll, Byrne, Carr, Chen, Gorwood, Johnson, Kärkkäinen, Krystal, Lee, Lieberman, López-Jaramillo, Männikkö, Phillips, Uchida, Vieta, Vita & Arango, 2020:812). Moreover, it has caused delays in detainees attending courts, temporary suspension of visits, suspension of group rehabilitation and recreational programmes, limiting communication with families etc. This necessitated a focus on preparing corrections for the prevention and/or managing of any COVID-19 cases. This has resulted in damaging effects on physical and mental health and on the reprioritisation of funds towards COVID-19 prevention of the disease and management strategies (Hewson, Shepherd, Hard & Shaw, 2020:568). Budgets given to corrections now have to be overstretched to cater for the "uncatered for". While annual budgets are available for health care programmes and services in most countries, it is not known whether or not these funds are used to a greater extent for the expenditures for the incarcerated mentally ill (Salize et al., 2007:27).

Proper mental health care remains a challenge in the corrections system (Fraser, 2014:173). Factors that contribute to poor provisioning of proper mental health care for detainees include high employee turnover among corrections officers, which adversely impacts on the success of rehabilitation, treatment, and care programmes, and ultimately leave criminals unimproved and more defeated than when they were incarcerated. Thus, upon release they are more likely to return to their life of crime (Stephen & Dudafa, 2016:2). Further to this, professional psychiatric personnel are scarce and the corrections system finds it difficult to attract these professionals.

Konrad and Opitz-Welke (2014:517) indicate that deviant behaviour of mentally ill detainees is misinterpreted as a disciplinary infringement which they get punished for. They are usually placed in disciplinary segregation instead of being referred to medical treatment. It is also very challenging to provide a therapeutic atmosphere inside isolation units/cells (Lekalakala, 2016).

According to some authors, poor mental healthcare is supposed to increase the risk of re-offending in individuals with mental health disorders (Gonzalez & Connell, 2014:2328; Konrad & Opitz-Welke, 2014:517; Lekalakala, 2016:23). That being the case, a study by Robinson (1996), cited by Stephen and Dudafa (2016:6), indicates that the completion of therapy reduced detainees' recidivism rate by 11%, compared to detainees who did not complete the therapy. Further to this, a meta-analysis of 69 studies on behavioural and cognitive-behavioural programmes, concluded that the cognitive-behavioural programmes were more effective in reducing recidivism (Stephen & Dudafa, 2016:5). The mean reduction in recidivism was about 30% for treated detainees. A general consensus is emerging in the literature, that structured, goal-oriented, cognitive, and behavioural therapies are successful in reducing recidivism, as they centre on the associations between beliefs, attitudes, and behaviour (Hyatt, 2013:47; United Nations Office on Drugs and Crime, 2018). It is therefore imperative that mental health in corrections be closely monitored and addressed because failure to do so may result in mentally ill detainees not responding to the rehabilitation or therapeutic programmes or any other intervention taken by the Department of Corrections (Lekalakala, 2016:23).

The debate on the effectiveness of rehabilitation is still ongoing. Countries that have invested in correctional and rehabilitation programmes have presented positive evidence of treatment success as indicated in the literature reviewed. Governments throughout the world invest in such rehabilitation and treatment programmes believing that this will improve the likelihood to deal with life in the community, which in turn will lessen reoffending. The World Health Organization (2005:2) strongly iterates that placing people with mental illness into treatment and rehabilitation early during incarceration will ultimately, in the long-term, lessen the corrections expenditures.

6.2 THE ROLE OF CORRECTIONAL STAFF

Since rehabilitation requires a multi-disciplinary approach, it is important to understand the roles of the various role-players. A psychiatrist plays a pivotal role and is responsible for diagnosing/assessing the mental problem and prescribing

medication. A psychiatrist must also lead a contingent of professional experts who must attend to mentally ill detainees to provide psychosocial interventions. This is important for a correctional environment, as it is known and proven that psychiatric personnel are scarce, and even more so in correctional facilities. The psychiatrist will need to lead/train the correctional services team to provide services such as the development of social skills, vocational rehabilitation, and psycho-education, as well as to provide community and family support (Rössler, 2006:154-155).

Coyle and Fair (2018:15) speak extensively on the topic of corrections' staff and iterate the important function that they fill in both the lives of the detainee and in administration, as well as in the proper functioning of correctional institutions. The ideal correctional staff should live up to the international guidelines discussed in Chapter 4 that outline the expectations of correctional staff. With reference to the Nelson Mandela Rules, Rule 77 states that all staff is required to respect detainees, be role models, and encourage detainees to be good and to conduct themselves in an exemplary manner. Respect, in itself, entails a myriad of connotations and this includes the respect for the detainee's human rights, and the provision of an environment that enables humane detention, an abuse of which could be a reason for upheaval in detention facilities as well as litigations against corrections authorities. Furthermore, the Basic Principles for the Treatment of Prisoners, Principle 4, calls for the correctional staff to develop and rehabilitate the detainee (Coyle & Fair, 2018:19). Corrections officials must recognise mental health concerns as part of the requirements of stabilising the security and safety of the facility. The integration of efficient mental health assessment, classification systems, and treatment programmes will assist officials to enable a safe and health- promoting environment (Posholi, 2019:25).

In addition, one must not lose sight of the other roles correctional officials play. These roles include ensuring the safety of detainees, staff, and community by preventing detainees from escaping. Other roles include the inspection of the facility to ensure that they meet safety and security standards. Furthermore, corrections officials are tasked to maintain "good order" in the facility by encouraging positive behaviour, and to provide detainees the opportunity to develop life skills to enable effortless integration into the community upon release.

A task of vital importance is for correctional staff to be trained on medication monitoring so that detainees do not misuse/abuse/not take the prescribed medication. A crucial role given to correctional staff is that of putting an end to any non-compliance with medication taking. This is regarded as one of the most significant difficulties in the long-standing treatment of people with genuine psychological illnesses (Rössler, 2006:155). A part of the rehabilitation process, and for authorities to consider possible release, is that the mentally ill detainee must reach a state of autonomy where he/she complies with medicine-taking independently (Coyle & Fair, 2018:19).

It therefore cannot be disputed that effective rehabilitation of detainees depends largely on correctionsofficers who have a direct influence on the behaviours of those who are incarcerated through their regular day-to-day contact with them, the "specialised" staff who are responsible for rehabilitation/reform of detainees, and very importantly, the community, for support systems that can avert recidivism (Stephen & Dudafa, 2016:1). Early studies into the effect that rehabilitation has on recidivism were very few, however, studies conducted between 1945 and 1967 led to a conclusion by Martinson (1974:25) and later supported by Cullen & Gendreau (2000:119 that "the rehabilitative efforts have had no appreciable effect on recidivism". Later studies by Van Voorhis (1987), cited by Stephen & Dudafa (2016:4), argued against this conclusion, indicating that "psychological" rehabilitation positively affected the non-return of criminals to the corrections system.

6.3 SOUTH AFRICA

6.3.1 Admission and Assessment

Correctional centres provide mental health services from admission until discharge, which include, but are not limited to, services provided by professional nurses, general medical practitioners, and psychiatrists, and to a limited degree, psychologists, spiritual care workers, and social workers (Department of Correctional Services, 2020b:29).

Some detainees already come into the correctional centre with a directive by a court of law indicating that they be detained as state patients in terms of sections 77 and 78 of the Criminal Procedure Act, 51 of 1977. The state patient will be issued with either a MC20, MC22 or J105 court order and may be temporarily detained in a correctional health facility, while waiting for a hospital bed (Department of Correctional Services, 2020b:60). In accordance with a J105 court order, the detainee is cared for in detention, or ordered by the Court to be transferred to a psychiatric hospital and discharged back to the correctional facility once rehabilitated (Department of Correctional Services, 2020b:60). In addition to this, the head of the correctional facility will ensure that proper medical treatment is provided to state patients in consultation with the relevant psychiatric hospital. This also applies to cases where a J138 order for a forensic mental observation is issued in terms of Section 79 of the Criminal Procedure Act 51, of 1977 (Criminal Justice System Review Board, 2016:9). The DCS is required to liaise with the designated psychiatric hospital to book a bed for the forensic mental observation (Department of Correctional Services, 2020b:60).

Research conducted by Prinsloo (2013:137), revealed that mental disorder warning sign indicators are: resentment; criminal inclinations; anti-social behaviour; and the premature commencement of anti-social behavioural disorders. He recommends therefore that tests be conducted on detainees, as the results can lead to early detection and become valuable inclusions to their all-inclusive sentence-planning approach and into a suitable needs-based treatment. Prinsloo (2013:135) further states that the main characteristics which contribute significantly as main predictors of mental concerns are a dearth of regret, emotions, and sympathy with victims.

It has been reported by Marais (2014:69) that risk assessment tools are not routinely used in most forensic psychiatric units in South Africa. The DCS, however, uses the risk–need–responsivity (RNR) model, which is contextualised within a general “personality and cognitive social learning theory of criminal conduct” (Prinsloo, 2013:133). This entails identifying the detainee’s risk to re-offend (low, medium, or high risk); assessment of the detainee’s criminogenic

needs; and providing a response to the risk and assessment needs in the form of interventions. The response decided upon is structured, clinically relevant, and psychologically informed, i.e. it is based on the psychology of the criminal conduct (Andrews, Bonta & Wormith, 2011:734). The RNR model builds on the strengths of the detainee to counter criminal activity whilst motivating the detainees to build positive relationships with their family and community to avoid "criminal inducing associations and behaviour" (Andrews et al., 2011:744). Rehabilitation programmes in DCS emphasise the delivery of appropriate needs-based programmes, and the social and economic functioning of detainees after release (Department of Correctional Services, 2005).

Rehabilitation in DCS is multifaceted and includes an initial assessment upon admission. This includes an assessment process that would profile the detainee, assess the security risk, and what critical vulnerability of the detainee that would require immediate intervention. At this point, the detainee is subject to a mental health status and a suicide risk assessment by a professional nurse that has psychiatric training (Department of Correctional Services, 2013).

This is not the only assessment that the detainee undergoes. The detainee is then referred to the assessment unit where a comprehensive health assessment must be conducted within 24 hours by a professional nurse (Department of Correctional Services, 2013). A comprehensive risk and needs assessment is also conducted at the assessment unit within 21 days by role players of the Case Assessment Team (Frantz, 2017:13). The Case Assessment Team comprises various components responsible for the assessing of the detainee's developmental needs, care needs, correction needs, social reintegration needs, security needs, and accommodation needs. They include psychological services, social work services, spiritual care services, health care services, security offender profiling, formal education, skills development, sports, arts, culture, and social reintegration (Frantz, 2017:13). This assessment is done to determine the major risks and needs of the detainee and the aim is to compile a holistic profile of the detainee considering all above aspects (Herbig & Hesselink, 2012:34). The Case Assessment Official from the Case Assessment Team will then provide a profile report to the Case Management Committee who will ensure that the detainee

endorses the sentence plan. A sentence plan is compulsory for every detainee that has been given a sentence of longer than 24 months. This sentence plan is part of the case file of the detainee. All recommendations are then populated into a structured day programme for detainees. The Case Management Committee is responsible for ensuring a proficient and coordinated approach to the incarceration, care, treatment, and development of all detainees throughout the entire incarceration period (Louw, 2008:67). The Case Management Committee is also responsible for making recommendations regarding the placement or release of sentenced detainees to the Correctional Services Parole Board (Frantz, 2017:16).

It must be remembered that the psychologist forms part of the Case Assessment Team. It is at this stage that he/she gets involved. If a detainee is found or is suspected to need mental health care, more information on the detainee is sought. The DCS uses various methods to obtain information. The most common being interviewing by the psychologist, and the use of psychometric tests. Further to this, in order to determine the detainee's social functioning, an observation is done of persons in group experiences. The DCS also finds that it is important to obtain information from "functional personnel" and from family or other individuals who may have any vital information of the person's mental state. The insight obtained from the various methods described above, creates the foundation for the psychologist deciding on a diagnosis and the making of pronouncements on a suitable treatment for the detainee who is found to be mentally unfit (Department of Correctional Services, 2020a). If the results from the psychologist's assessment show that the detainee is mentally ill, he/she is referred to the clinical psychologist or the psychiatrist for expert diagnosis. Currently there is no psychiatrist employed by the DCS so the detainee will be referred to an external psychiatrist.

All cases are reviewed every three months by the Case Review Team and a report is submitted to the Case Management Committee. This report includes progress reports from all professional groups relating to the detainee's correctional sentence plan. According to Louw (2008:87), many detainees are paroled without seeing a psychologist owing to the critical shortage of psychologists. This would

result in mentally ill detainees who were not previously diagnosed nor detected in the system to also undergo the case review process. During the period of incarceration, the detainees are observed for any behavioural changes that might be indicative of pointers towards mental illness, such as confused thinking, prolonged depression (sadness or irritability), feelings of extreme highs and lows, excessive fears, worries and anxieties, dramatic changes in eating or sleeping habits, strong feelings of anger, delusions, hallucinations, or frequent memory loss (Mental Health America, 2020).

The Case Management Committee reviews the progress and may approve recommendations of the Case Review Team and update the case file accordingly (Department of Correctional Services, 2013; Du Plessis, 2017:170). Suspected cases of mental illness are then handed over to a sessional doctor of psychiatry or a public establishment such as a forensic psychiatric hospital for a proper analysis and if necessary, for treatment and care (Department of Correctional Services, 2020b:29). The case file of the detainee is endorsed as such. Whilst waiting for the psychiatrist's diagnosis, the mentally ill cases are then checked upon on a monthly basis and further monthly assessments are done by the psychiatrist. Upon diagnosis and being declared mentally ill, based on the review process by the Case Review Team, the patient will be referred to the hospital unit/sections and accommodated there to be tended to by psychologists or psychiatrists if available (Department of Correctional Services, 2020a). Types of mental illnesses that are treated in the South African DCS comprise of, amongst others, schizophrenia, bipolar mood disorder, psychosis, substance abuse, and personality disorder. Professional nurses are tasked to give the mentally ill their medication if it is prescribed (Department of Correctional Services, 2020a).

6.3.2 Rehabilitation

The South African Government has outlined a National Development Plan which focuses on the achievement of a "decent standard of living" for all South Africans by 2030. One of its aims is to "strengthen the effectiveness of the criminal justice system" (Republic of South Africa, 2011b:25-26). The rudimentary pillars of the National Development Plan necessitate that the DCS rehabilitates its detainees to

become economically active members of society. This is done through the provision of several programmes such as correctional programmes, education, social work, psychological and spiritual care services, which have to be appropriate, needs based, and responsive to the economy (Department of Correctional Services, 2005).

Rehabilitation for the mentally ill, and as this is defined in the Mental Health Care Act 17 of 2002 refers to “a process that facilitates an individual attaining an optimal level of independent functioning” (Republic of South Africa, 2002:5). This simply means to prepare someone to resume normal life through the provision of therapy, care, treatment, and life skills (Rössler, 2006:151).

The South African DCS provides psychological services to detainees under their budgeted programme Rehabilitation. The aim of this programme is to make needs-based programmes and services to detainees that would enable their social reintegration. In an effort to decrease reoffending, the Department of Correctional Services (2019a:21) focused in the 2018/2019 financial year on increasing and improving rehabilitation programmes, and on getting more detainees involved in rehabilitation interventions. Rehabilitation programmes fall into the following categories (Department of Correctional Services, 2019a:76):

- Correctional programmes which are needs-based programmes aimed at “fixing” the criminal behaviour.
- Development programmes which aim to facilitate detainee’s personal development by ensuring access to literacy, educational, and skills proficiency programmes.
- Psychological, Social Care and Spiritual Care - These interventions aim to improve the health and emotional wellbeing of detainees.

The rehabilitation of offenders is managed at National Head Office by a structure as shown in Figure 5 below.

It is clear in Figure 5 that although psychologists provide rehabilitation programmes associated with mental health; mental health is provided for as

primary health care residing under DCS Health Care Services. It can immediately be seen that the services are looked at from a multi-disciplinary perspective. The level of health care provision is at secondary and tertiary level which refers to psychiatric treatment being provided by specialists (psychiatrists) either on-site or externally at tertiary and / or at academic hospitals (Department of Correctional Services, 2020a).

Figure 5: Organogram of the Rehabilitation Programme in the South African Department of Correctional Services

Source: Adapted from the Department of Correctional Services (2019c)

An detainee's involvement in programmes is voluntary; however, the courts may order that the mentally ill person undergoes treatment/therapeutic programmes (Department of Correctional Services, 2020a). The reason for a mandatory court order would be to maintain the patient's mental health, to continue with treatment, or to prevent the recurrence of the mental disorders (Institute of Medicine and National Research Council, [sa]:207). Correctional treatment ordered by courts are intended to target the offending behaviour with the ultimate aim of reducing recidivism (Hatchel, Vogel & Huber, 2019:1). An example of this is if the crime

was linked to the mental status of the detainee, such as assault whilst under the influence of drugs, then the detainee could be ordered by the court to attend the substance abuse programme. In these cases, there is no option but for the detainee to undergo the treatment/therapy as ordered.

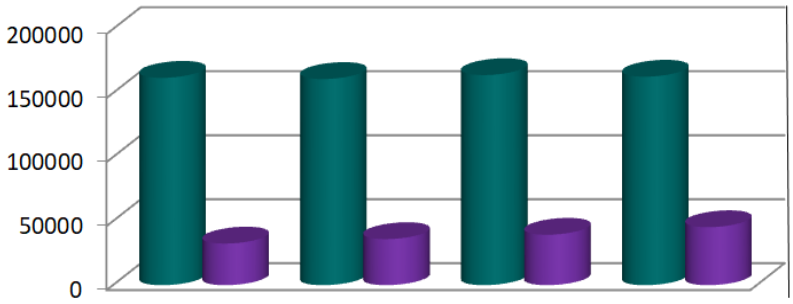
Psychological programmes are also marketed to the detainees, and therefore a level of responsibility also lies with the detainee to access these programmes. A request can be made in this regard through a complaint and request process where detainees are given an opportunity on a daily basis to request assistance, or this can be done through their case officers. A case officer is an official who is responsible for monitoring and managing the daily activities of each individual offender allocated to him/her as outlined in the correctional sentence plan. The case officer updates case files for each detainee allocated to him/her, which should be a maximum number of 40 detainees (Department of Correctional Services, 2013; Du Plessis, 2017:150).

The DCS had 182 state patients who were being held in detention facilities instead of psychiatric hospitals (Ellis, 2019). The majority of these patients, 87, were incarcerated in the Eastern Cape Region (the DCS has clustered the various provinces into regions). Gauteng only had four state patients, KwaZulu-Natal had 35, Limpopo, Mpumalanga and North West a combined 17 and the Free State and Northern Cape a combined 39. Further to this, of the 87 that was incarcerated in Eastern Cape only one person had accessed a psychiatrist and state patients were being accommodated in the general cells with other detainees (Ellis, 2019). The outgoing inspecting judge for Correctional Services, Justice Johann van der Westhuizen, said “the issue of state patients being held in correctional facilities instead of psychiatric hospitals had essentially remained unchanged in the past year [2018]” (Ellis, 2019). In a written response to this statement, the Directorate of Health from DCS was quoted as saying that although working together with the National Department of Health has assisted in removing state patients from DCS, there are always new admissions (Ellis, 2019). According to Posholi (2019:15) this remains the case, although the DCS does not have psychiatric facilities or psychiatric units at correctional facilities.

The Department of Correctional Services (2019a:19) refers to state patients detained in correctional centres being provided with relevant health services including the provision of psychiatric treatment. Further to this, psychological programmes are offered to detainees that are a suicide risk, detainees who have previously received psychiatric or psychological treatment, mentally ill detainees, detainees who have been referred for psychological programmes by court, aggressive and/or sexual offenders (Department of Correctional Services, 2020a). Mental health services include orientation, assessment, diagnosis, treatment, on-going care (counseling), rehabilitation, and referral (for common diseases) of all mental health care users including periodic reviews, counseling and support services (Department of Correctional Services, 2020a). Interventions are tailored to the specific needs of detainees. So, psychologists develop programmes in line with what detainees seek help for.

The Department of Correctional Services (2019a:19) does not specify the types of psychological programmes attended by detainees but rather gives statistics that show the numbers of detainees that attended psychological services over a period of four years as indicated below.

Figure 6: Trends: Numbers of detainees that attended psychological services from 2015/16 – 2018/19.



	2015/2016	2016/2017	2017/2018	2018/2019
No. of inmates in DCS	161984	161054	164129	162875
Inmates in psychological Services	32523	36014	39407	45331

Source: Adapted from: Department of Correctional Services, 2019a:19

According to Figure 6, there has been a steady increase in the percentages of detainees accessing psychological services in the DCS (from 20,8% in 2015/2016

to 28% in 2018/2019). The DCS does, however, indicate that not all programmes can be offered to detainees, due to the shortage of psychologists nationally (Department of Correctional Services, 2020a).

The following psychological rehabilitation and therapeutic technique programmes are offered to detainees (Department of Correctional Services, 2020a):

- Individual Psychotherapy which involves thorough focus on one problem at a time, but also on a one-to-one basis with the psychologist. This is aimed towards encouraging an individual to learn behaviour that is more socially acceptable, come to terms with anxiety, how to manage anxiety, trauma, hostile or violent compulsions.
- Group Therapy of approximately 8 to 12 persons with similar problems. This programme aims to teach acceptable behaviour and improve or expand interactive skills.
- Couples and/or Family Therapy aims to strengthen ties with families and is enabled whilst in incarceration or after discharge.
- Other structured programmes provided to detainees include anger management. These programmes are presented by psychologists together with social workers and functional personnel.

6.3.3 Release

Psychologists and/or psychiatrists will assess and evaluate participation and progress and endorse the profile report to the Case Management Committee in preparation for a decision for placement on parole to be made by the Correctional Supervision and Parole Board. This is provided for in s73 of the Correctional Services Act (Republic of South Africa, 2015:54; Louw, 2008:64). Detailed reports from the psychologists may also be attached to the profile report for possible placement on parole. Detainees are also medically assessed before release on the sentence expiry date.

Medical parole on the other hand, is considered when a sentenced detainee is discharged because of ill health, because he/she suffers from a severe illness, or

is unable to care for himself/herself. The detainee, a medical practitioner or family or any person acting on behalf of the detainee may apply for medical parole (Republic of South Africa, 1998). This sadly does not apply to those that are mentally ill.

6.3.4 Challenges

South Africa has a long history of overcrowding in their correctional facilities spanning over 50 years. The dramatic increase in the detainee population from 95 070 in 1991/92 to 162 875 31 March 2019 has forced the DCS to look at strategies to alleviate the dire situation (Department of Correctional Services. 2019a). Remand detainees made up as much as 29% of the detainee population. The DCS recorded 37% overcrowding in March 2020 (Department of Correctional Services, 2019a:46).

South Africa has not escaped the challenges that are created by overcrowding and it has had an impact on every facet of the operations of the South African Correctional System (Cilliers & Smit, 2007:83). These challenges include the lack of appropriate facilities to accommodate the mentally ill. The majority of the DCS facilities are outdated and old and not conducive to the treatment and care of mentally ill detainees. Upon admission, if there is clear indication on the J138 court order, the accused will be admitted into the inpatient facility of the correctional centre or a single cell; and arrangements for admission at designated mental health care institutions for observation / treatment are made through courts or as per referral as according to the Mental Health Care Act 17 of 2002. Sadly, however, beds are not always available within the stipulated times (Judicial Inspectorate for Correctional Services, 2019:10). The J138 is a form used to authorise the detainee to be sent to a correctional facility for psychiatric observation in terms of Sections 77 to 79 of the Criminal Procedure Act, 1977.

Accommodation for the mentally ill is a challenge to the South African DCS. The seriousness of an detainee's mental disability will depend on whether the detainee is housed in a single or a communal cell. The less severely mentally ill are accommodated with the general population and the severely ill are accommodated

in the medical facility. All mentally ill patients receive regular treatment. State patients spend long periods in the DCS facilities. This was confirmed by the Judicial Inspectorate for Correctional Services. The team from the Judicial Inspectorate for Correctional Services who visited correctional facilities found in 2017 that 2730 mentally ill detainees and 90 state patients were being accommodated in DCS facilities. The number of state patients remained the same when a follow up visit was conducted in 2018. The reasons quoted for this was that there was no bed space available at the health institutions or forensic psychiatry hospitals (Judicial Inspectorate for Correctional Services, 2019:27).

There is a lack of professional staff in the DCS to conduct rehabilitation (Cilliers & Smit, 2007:98), as depicted in Table 13 below. The DCS had in its employment 2086 qualified professionals (information for the 2018/2019 financial year) and only 1572 health and wellbeing professionals to provide services to 162 875 detainees. This computes to a ratio of one health and wellbeing professional to 104 detainees. Further to this, the ratio of medical practitioners to detainees stands at 1: 23 268 detainees and one psychologist/vocational counselors to 2 011 detainees. Table 13 also depicts a grey picture in terms of the turnover rates. The highest being that of medical practitioners (58,8%), followed by pharmacists (21,2%), professional nurses (17,2%), and psychologists (16,5%); yet literature indicates that good practice in managing the mentally ill is to ensure medication is dispensed and taken on time (Bowen, Rogers & Shaw, 2009:1-4). This seems like a feat that may be impossible for the DCS.

Table 13: Rehabilitation staff, approved establishment, vacancy, and turnover rates.

Category	Approved establishment	Number of posts filled	Vacancy rate	Turnover rate
Educationists	**600**	**514**	**14.3**	**3.5**
Medical practitioners	17	7	58.8	60
Pharmacists	52	41	21.2	13.,1
Professional nurses	1025	849	17.2	7.4

Category	Approved establishment	Number of posts filled	Vacancy rate	Turnover rate
Psychologists and vocational counsellors	97	81	16.5	36.7
Social work and related professionals	639	594	7	4
Total Rehabilitation	**2430**	**2086**	**Health and Wellbeing Staff to Detainee ratio is 1:104**	
Total Health and Wellbeing (Without Educationists)	**1830**	**1572**		

Source: Department of Correctional Services, 2019a

There are no psychiatrists employed by the DCS, however 64 sessional psychiatrists (ratio 1: 2 545) are obtained from the public and private sectors. This too is a challenge, as the time with a patient is limited and full therapeutic and treatments sessions are rushed. Due to the challenges being experienced in public hospitals, detainees directed for observation end up being kept in incarceration for longer periods of time without being attended to. It has been indicated that the referral process between the DCS and the National Department of Health mental health facilities is a lengthy one, and often results in mentally ill detainees being kept in DCS facilities for longer periods of time. Courts also experience administrative challenges resulting in the appointed psychiatrists not being informed timeously of their new observation cases. Of grave concern cited, is that observandi are mollified with psychotropic medication and actual conduct and depressive symptoms of the mentally ill are “masked” thus making it extremely demanding to conduct behaviour analysis (Moncrieff, Cohenb & Porterc, 2013:411).

In addtion to the shortage of nurses, those that are employed are inadequately experienced professional nurses, although some do possess the required four-year Diploma in Nursing, be it as a general nurse, a psychiatric nurse, or a community nurse, or as a midwife (Department of Correctional Services, 2019a:106). Of the 33 489 custodial officials, none have been given training on their tasks and responsibilities associated with mental health care services (Department of Correctional Services, 2019a:106). The Judicial Inspectorate for

Correctional Services (2019) confirms that state patients are often unpredictable and must be treated and supervised by trained professionals. Evidently this is not happening in the South African Corrections systems (Judicial Inspectorate for Correctional Services, 2019:28). Further to this, it was picked up by the Inspecting Judge Johann Vincent van der Westhuizen, during his visit to DCS facilities that DCS security officials manage state patients on a daily basis although they are "simply not trained" to deal with the mentally disabled. Their provisional incarceration in correctional facilities, awaiting their transfer, is regarded as harsh and callous (Judicial Inspectorate for Correctional Services, 2019:28).

Salize et al (2007:27) cite insufficient budgets being apportioned to health care in corrections and this is also the case with the DCS. Funding for rehabilitation programmes and services utilised by the South African DCS amounted to R1 749 billion, and that for Health and Hygiene amounted to R2 287 billion. This is 17% of the whole budget spent by the DCS in 2018/2019 which had to be spread over the whole detainee population of 162 875 (Department of Correctional Services, 2019a: 24).

Cilliers and Smit (2007:99) indicate that the DCS does not have a current "scientific system or mechanism" to measure recidivism rate of detainees. The DCS does not deny that there are no reliable statistics on the rates of re-offending in South Africa and recommends a reliable system to be put in place (Department of Correctional Services, 2005:74).

Despite the lack of a reliable system to measure recidivism rate, one can make a deduction from the various studies conducted that the recidivism rate among state patients and mentally ill persons in the DCS is high. Naidoo and Mkhize (2012:31) found a recidivism rate of 21,7% in their study carried out at Westville Correctional Centre from January to February 2009. In a study conducted by Marais and Subramaney (2005:89-90) on 114 state patients at the Sterkfontein forensic psychiatry facility in 2004 and 2005, it was found that 4% of state patients recidivated within a three-year review period. There was no record of reoffending in 90% of the state patients. In a later study conducted in 2018 by Morgan and Del Fabbro (2018) on inpatients at the very same forensic psychiatry facility, it was

found that 80 of the total 180 state patients were recidivists. According to Khwela (2015:410), high recidivism rates of mentally ill detainees could be attributed to the mentally ill patient not being “deterred by the sanction imposed”, treatment was ineffective, or the rehabilitation programmes were not effective. The likelihood of re-offending for the mentally ill could prevail until the challenges of mental health, as discussed, are addressed (Khwela, 2015:410).

6.4 GERMANY

Corrections authorities cannot choose the detainees that they admit at their facilities, but they can administer controls to identify poor mental health in newly admitted detainees (Durcan & Zwemstra, 2014:91).

6.4.1 Admission and Assessment

The Prison Act of 1976 has made provision for both open and closed prisons based on the mandates of the Act, namely, rehabilitation and normalisation. Normalisation requires that living conditions inside detention facilities should resemble conditions outside detention facilities as much as possible (Osment, 2018:10). Rehabilitation programmes offered in German detention facilities, include educational, vocational, life skills, psychosocial, therapeutic (occupational therapy, substance abuse prevention, and other treatments), mental health services, and recreational programmes. In order for rehabilitation programmes to succeed proper screening and assessment must be conducted (Osment, 2018).

Generally, screening for mental health occurs immediately after admission by a general practitioner. Initial screening for the most observable signs of poor mental health or for the most evident risks is extremely important to ensure that immediate attention is given to those who need it. Initial screening is also useful to detect the existence of any mental disorders prior to the incarceration of the detainee as opposed to mental disorders acquired during incarceration. Initial screening by a psychologist or a psychiatrist is not common in Germany and regular rescreening for mental illness is not compulsory (Salize et al., 2007:28). Although initial screening usually relies on information being provided by the

detainee him/herself or obtained from the documentation they come with, it is imperative that follow-up screening should follow, to detect signs of mental health history; gauge the detainee's current mental health; look for symptoms of poor mental health; ascertain if there are any addiction problems; or to "gauge" likely behaviours signifying personality disorders or risk of suicide (Durcan & Zwemstra, 2014:91). Opitz-Welke, Konrad and Völlm (2020:2) also caution that due to the high occurrence of violence in detention the screening instruments must be of such a nature that they must be capable of detecting individuals at risk of acting violently, and the screening must be conducted by medical staff.

In some states, such as those visited by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), namely, Celle (Lower Saxony), Kaisheim (Bavaria), Tonna (Thuringia), Rosdorf Prison (Lower Saxony), Berlin-Moabit Prison, and Berlin-Plötzensee Prison Hospital, from 25 November 2015 to 7 December 2015, it was found that a doctor or a nurse (under the supervision of a doctor) would ordinarily see to a new admission within 24 hours and the medical history is recorded in two files. One file is for the detainees' consumption and the other is only for the medical staff (Council of Europe, 2017:25). In other states, the initial assessment is carried out by a social worker who is also pivotal in developing tailored sentence plans for each detainee to address his/her rehabilitation (Osment, 2018:32).

Once the initial screening shows signs of a mental disorder, the risks to the detainee's safety and to the safety of others is assessed. In addition, assessment takes place to determine the severity of the mental illness (Opitz-Welke et al., 2020:2). Violent behaviour crimes are also assessed in order to determine the risk to the staff and other detainees (Opitz-Welke et al., 2020:2). The detainees who have committed more serious crimes are referred to the prison psychologist for further assessments.

Risk and needs assessments are conducted by utilising various reliable, suitable, and valid risk assessment instruments such as the Level of Service Inventory—Revised (LSI-R), and the Psychopathy Checklist–Revised (PCL), amongst others (Lehmann, Neumann, Hare, Biedermann, Dahle & Mokros, 2019:2; Trestman et

al., 2007:232). In addition to the mentioned instruments used, risk assessment is also performed by using file records, direct patient interviews, and team discussions (Trestman et al., 2007:232).

In Germany, these instruments are custom-built to assess the different areas of mental health, criminogenic needs, and criminal conduct. Once the psychiatric and criminogenic needs are identified during assessment, they are actualised as treatment targets. Thereafter, a clear plan is developed which specifies how change is to be accomplished for each target (Trestman et al., 2007:232). Separate department personnel (experts) participate in this process. Once a detainee is admitted and starts their sentence they are given the essential counselling, prescription and treatment (Osment, 2018:32).

Access and admissibility to psychiatric care must be granted by the corrections physician. The groups of patients referred to psychiatric care are those patients with psychosis, which includes substance-induced psychoses, mood disorders, or severe personality disorders. Quite often the stress of imprisonment, and the unique conditions within detention facility walls, cause a severe exacerbation of existing mental problems (Lehmann, 2012:133). The Berlin Senate Department for Justice and Consumer Protection (2015:25) clearly indicates that the need for education, therapy, and treatment is carried out by experts with degrees in psychology or social work, who also assess for the risk of recidivism.

Continued monitoring of detainees with potential risks is essential as it can prevent high dropout rates from detainee interventions. Research by Brunner, Neumann, Yoon, Rettenberger, Stück and Briken (2019:1) indicates that one third of detainees that were admitted to social-therapeutic correctional facilities in Germany did not complete treatment. This can lead to higher rates of behavioural problems (Brunner et al., 2019:8); thus posing a potential risk to the safety of staff, other detainees and the public once released (Brunner et al., 2019:1).

6.4.2 Rehabilitation

Mental health for detainees follows what is termed a mixed model, i.e. it is provided both internally and through external service providers. In Germany, however, external amenities dominate (Salize et al., 2007:19). Only seven federal states, namely, Baden-Württemberg, Bavaria, Berlin, Lower Saxony, North Rhine-Westphalia, Rhineland-Palatinate, and Saxony have autonomous psychiatric departments in their detention facilities. Because the various states are governed by their own prison acts, the care and treatment offered are not standardised. Some states enter into agreements with forensic or general psychiatric institutions to provide mental health care and psychiatric treatment (Cuéllar, Tortosa, Dreckmann, Markov & Doichinova, 2015:67). In Berlin, the mentally ill are provided specialist care in the Department for Psychiatry and Psychotherapy in the Berlin prison hospital. There are three units which focus on various treatments for the mentally ill. One unit treats psychotic schizophrenic patients who are dependent on substances and therefore require a multidisciplinary approach to treatment. The other two units treat patients with personality disorders or adjustment disorders (Salize et al., 2007:157). Mentally ill detainees can be accepted at the prison hospital at any phase of their stay in the facility, however, there is a waiting list because of limited bed space. Mentally ill patients are also treated as outpatients whilst awaiting space (Seidel et al., 2019:2).

Every mentally ill patient has a treatment plan developed in line with his/her needs and this may include “pharmacological treatment, psychotherapy, group therapy, occupational therapy, art therapy, music therapy, addiction therapy, athletic training and team sports”. Patients with severe disorders are placed in specialised treatment rooms for a limited time (Lehmann, 2012:133). German prison directives dictate that only male mentally ill detainees receive treatment in the prison hospital department of psychiatry. Female detainees receive treatment as outpatients or are transferred to a forensic psychiatric ward external to that of the detention facility (Lehmann, 2012:133; Seidel et al., 2019:2). Mentally disordered detainees who committed serious crimes could be taken directly to forensic psychiatric hospitals rather than to a corrections facility (Seidel et al., 2019:4). Whilst detainees are guaranteed continued medical care during the course of their

incarceration, this continuity is not guaranteed after the detainee's release. Cuéllar et al (2015:27) state that this is also true for those entering the detention facility, but they maintain that 70% of the maintenance programmes are discontinued once the affected detainee has entered the detention facility.

The study by Osment (2018) concluded that detainees in "open prisons" are more steadily "reformed" compared to those in closed prisons due to more rehabilitation programmes being offered in the open prisons. The ultimate aim of rehabilitation programmes is to reduce the criminal behaviour of the detainee and to reform the detainee.

Specific programmes are used for the treatment of mentally disordered detainees who committed sexual crimes. It is also compulsory for all sexual offenders with a sentence of more than two years to attend sex offender treatment programmes (Salize et al., 2007:34). Although treatment programmes for sex offenders are a legal requirement in some states, they too, vary in terms of quality (Salize & Dreßing, 2005:46). Germany also places emphasis on interventions addressing suicide deterrence. Prison authorities are legally required to provide adequate care and treatment for all detainees with problems or disorders relating to sexual abuse.

Further to this, Germany places a lot of attention on the high incidences of substance misuse. The mental health of detainees is of paramount importance in Germany because the majority of their detainees are reliant on drugs. Mental illness caused by substance abuse was found to have a prevalence of 50,25% among compensation prisoners, while its prevalence varied between 21% and 38% among general detainees, and was only 10% in the general population (Cuéllar et al., 2015:25; Schildbach & Schildbach, 2018:3). Even the Prison Act 1976 specifies that all 16 states must treat substance abuse, yet only six states do this, and even then, there is insufficient substance abuse treatment available (Osment, 2018:14). Osment (2018:14) also indicates that despite a requirement by law to provide substance abuse treatment to every detainee diagnosed with the disorder, implementing substance abuse treatment is still an underdeveloped element of the rehabilitation process in Germany. Admission criteria to the

treatment programme differs in the six states often leading to many not accessing the programme.

Courts in Germany denied detainees the right to state-funded psychotherapy (Cuéllar et al., 2015:66). They based this argument on psychological disorders not being covered in the the definition of illness in Section 58 of the Federal Prison Act (Cuéllar et al., 2015:66). Section 58 titled “Therapeutic Treatment” states that:

> “prisoners shall be entitled to therapeutic treatment provided that it is necessary to diagnose or cure a disease, prevent it from deteriorating or alleviate its symptoms. Therapeutic treatment shall include in particular medical treatment, dental treatment, including supply of dental prosthetics, supply of drugs, dressing material, medicines and medical aids, and medical and supplementary services with a view to rehabilitation, as well as functional tests and occupational therapy, unless barred by the interests of imprisonment” (Federal Republic of Germany, 2013:15).

Osment (2018:15) outlines the various psychological programmes that are offered in German detention facilities which endeavour to change the individual detainee’s behaviour. Besides substance treatment, there are a variety of therapies administered in detention. These include therapeutic programmes such as insight-based therapy, cognitive therapy, and behavioural therapy. Psychological interventions focus on using behaviour modification, social learning, and cognitive-based therapies to try and change detainee behaviour. Osment (2018) affirms that cognitive-behavioural therapy is the most successful therapy of all the rehabilitation programmes and has been effectively implemented in community corrections, juvenile facilities, adult detention facilities, and substance abuse programmes.

Detainees are given the opportunity to work and to join developmental programmes, as German prison law makes it obligatory for detainees to take part in education and training programmes or to work. A rehabilitated detainee is considered to be an individual that has the ability to work but must also be educated (Osment, 2018:34). They are allowed to take part in one programme at a time.

The psychologists who are working in detention facilities possess specialised professional qualifications. Some of these qualifications must include specialist legal psychology or a licence to practise psychotherapy. They work as social therapists, and psychotherapists, and provide psychological counselling. Their duties include planning for and implementing treatment programmes; they work in suicide prevention; they liaise with external treatment centres, and registered psychotherapists. Psychologists provide expert reports for transfers to an open prison or for the granting of privileges. Some psychologists also work in leadership positions, assuming personnel and managerial responsibilities as well. Further to this, the doctors employed in the detention facility hospital work in the specialist departments for psychiatry and psychotherapy (The Berlin Senate Department for Justice and Consumer Protection, 2015:33). Detainees do not have a choice of a preferred doctor. Medical treatment is guaranteed by prison doctors or contract doctors.

Mental health care staff must be appropriately trained and have the necessary proficiencies to manage adverse detention conditions confronted by detainees. The conditions in detention facilities associated with incarceration faced by mentally disordered detainees are: escalating psychiatric comorbidity; rising prevalence of anti-social personality conditions; and behaviour associated with violence and aggression. Such training may include training to address specific psychological problems, rehabilitation strategies, reintegration after release, medicinal continuance, safety concerns, and legislation for detainee health care provision or other facets of health care (Salize et al., 2007:25).

In addition to the standard job training which is a requirement for employment in the medical prison, there is a legal requirement in Germany for medical staff to undergo additional training or qualification. Nurses in Germany must qualify as corrections officers. In South Africa, nurses undergo basic training in corrections (Salize et al., 2007:24).

6.4.3 Release

The regulations found in the German Code of Criminal Procedure make provision for detainees with severe mental illness and life-threatening diseases to be released, especially if the detention facility cannot treat such a health issue or mental illness. According to Section 455 of the Federal Criminal Code, a prison term can be delayed prior to its starting in cases where the mental illness is of such severity that it cannot be treated in a prison or a prison hospital. However, if it is proven that the detainee still poses a threat to the security of the community, he/she will remain in detention even if they cannot be treated there, but he/she can be taken to an external institution for treatment and be brought back to the detention facility (Cuéllar et al., 2015:70). In this case, the prison provides the security, even during the consultation sessions or examination sessions in some cases, to ensure that the detainee does not escape if he/she is transferred to forensic psychiatric clinics for diagnosis and treatment.

However, before the mentally ill detainee is considered for discharge there is an obligatory assessment that must be conducted at the forensic psychiatry hospital on the mentally ill detainee to assist in taking an informed decision on the suitability to be sent to prison to start his/her prison sentence (Salize & Dreßing, 2005:58). Once an offender is incarcerated, their health insurance ceases and the prison system takes over the costs for any treatment that the detainee may require (Lehmann, 2012:133).

Yet when the mentally ill detainee is being released from the prison, there is no assessment of the detainee's mental state before he/she is released, and there is therefore no concrete psychopathological information to plan for adequate release strategies which may include referrals to psychiatric after-care services, as cited by Salize et al (2007:43).

With the enactment of the Reform of the Parole System and Amendment of the Provision for Subsequent Preventative Detention Act 2007, came the "therapy order" where parolees were instructed to seek psychotherapeutic, psychiatric therapy, or socio-therapeutic care and treatment. Therapists play an important

role when such therapy is ordered by court. They are under obligation to disclose any confidential information to the courts or the parole officer, if the information is deemed to assist the parolee from reoffending. Further to this, the therapists must report to the parole officer if the parolee fails to attend court. This relationship is considered very sensitive because the role of the therapists has to be balanced between that of therapist (who the parolee should be able to trust) and that of an "informer" (Konrad & Lau, 2010:236 – 238).

6.4.4 Challenges

There is a general insufficiency of specialists in medicine. This includes physicians with high qualifications as well as nurses to attend to mentally ill detainees. This can be attributed to the low starting salary, especially of doctors in corrections.

The challenge faced by Germany, is that mental health screening at admission is generally conducted by inadequately trained staff who do not conform to legal and quality international standards. They are also not equipped to detect the most predominant mental illness in the detainee, nor can they detect psychopathic behaviour or symptoms, thus compromising the quality of medical screening (Salize et al., 2007:28). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment indicates that the above challenges lead to administrative problems where there is no uniformity in the recording of injuries across the states (The Berlin Senate Department for Justice and Consumer Protection, 2015:31).

During the visit by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment to prisoners in Germany, it was found that a psychiatrist visited the Celle and Tonna Prisoners weekly for at least half a day, whereas a psychiatrist was working permanently full-time in the post of the head of the socio-therapeutic unit at Kaisheim Prison. Further to this, nurses worked seven days a week but not at night. This was an area for concern, as the Kaisheim prison had a 12-bed hospice facility. What was also of concern, was that psychotropic drugs were dispensed by custodial staff at the Celle and

Kaisheim prisons (The Berlin Senate Department for Justice and Consumer Protection, 2015:30). The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment received complaints from the mentally ill at the Kaisheim Prison that the heath care staff were often rude, used foul language, and were disrespectful towards them (The Berlin Senate Department for Justice and Consumer Protection, 2015:26).

Lehmann (2012:136) on the other hand, indicates that the collective role of being a guard and a nurse is often the reason for complaints from the psychiatric nursing staff. In addition to this, psychiatric nursing staff complain of poor working conditions. This situation still seems to be the case in some states, whereas there have been better resourced and capacitated prison hospitals in other states. For example, in the Berlin prison hospital, found within the Plötzensee correctional centre, there are specialist psychiatric and psychotherapeutic departments who administer internal medicine (The Berlin Senate Department for Justice and Consumer Protection, 2015:27).

Working in a corrections is one of the more hazardous jobs, as one is working in close contact with probable dangerous clients (Lehmann, 2012:136). One has to be highly qualified on corrections matters as well as have excellent communication skills and stress resistance because of the various groups of detainees that one would work with on a daily basis (Lehmann, 2012:136). Added to this, is that one finds even foreigners within the system, and therefore there is a need for staff to be multilingual (Lehmann, 2012:136; The Berlin Senate Department for Justice and Consumer Protection, 2015:22). Capabilities and skills required would be stress management and conflict management skills amongst others (Osment, 2018:46). Because working with the mentally ill is even more demanding than working with other medical patients, credentials in substance abuse and a minimum elementary skill in psychiatric therapy is essential in Germany (Lehmann, 2012:136).

Trained, experienced, and sufficient mental health care staff are crucial to the rehabilitation of mentally ill detainees. Although the principle of equivalence should apply to all institutions that accommodate and treat the mentally ill,

Lehmann (2012:132) indicates that the legal guidelines regarding the staffing of psychiatric treatment units are not followed by all corrections authorities. Unfortunately, it has been ascertained that no international guidelines are available on the minimum staffing required for mental establishments (Salize et al., 2007:24). However, basic psychological, psychiatric, and nursing capability should be available at all times to consider the urgency of referrals, take care of emergencies, provide psychological counselling, provide care for people in psychological distress, and provide counselling for those who can't cope with life in incarceration.

Further to this, detainees are more prone to "self-harming behaviour and suicide" (Opitz-Welke et al., 2020:2). Many authors agree that the suicide rate among detainees is much higher when one compares this with that in society. It is evident that detainees have increased mental vulnerability (Opitz-Welke et al., 2020:2). Hausam, Lehmann and Dahle (2019:2), acknowledge that providing an environment conducive to therapy in detention is challenging, and therefore correctional officials must be well trained in correct behavioural ratings of detainees. This is important for better offender risk assessment, which can detect vulnerabilities early upon admission.

An detainee suffering from a psychotic episode, and who requires acute treatment and care, will be treated as a psychiatric inpatient at a prison hospital or a prison medical ward, or will be referred to a forensic psychiatric hospital (if diminished responsibility is proven), or be referred to a general psychiatric hospital. Standards require that wherever the detainee is treated, he/she must receive treatment that is akin to that of the general population (Salize et al., 2007:31). Yet, mentally disordered detainees who require treatment at the prison medical wards or prison hospitals report longer waiting times to get there (Salize et al., 2007:33).

Although emphasis is placed on rehabilitation of German detainees, Opitz- Welke et al (2020:2) are of the opinion that short periods spent in incarceration do not do justice to any long-term rehabilitation programmes. Schildbach and Schildbach (2019:3) studied compensation prisoners from 1999 till 2017. They chose four

samples of 100 such detainees and found that the majority of compensation prisoners are poor, homeless, unemployed, and showed a high frequency of mental illness. The average detention period of compensation prisoners in detention is three to four months. This short period results in the non-provision of social rehabilitation programmes before release. They established that imprisonment of such detainees could be dealt with in a better manner, as their short encounter in detention can lead to criminalisation and further mental distress.

In a study to determine dropout from correctional offender treatment, Brunner et al (2019:1) examined 215 violent male detainees receiving psychotherapy, and found that 33,3% of those who attended social-therapeutic programmes (sexual and violent) in social-therapeutic correctional facilities dropped out of their treatment. It was also found that the dropout rate from treatment was linked to greater reoffending.

Germany, unlike the other countries from the study, does not face the challenge of overcrowding. In the visit conducted by the Berlin Senate Department for Justice and Consumer Protection, they concluded that nowhere in the German states was there any overcrowding. The Kaishem prison had 584 and could accommodate 640 detainees, Celle Prison accommodated 184 of the 222 that it could have accommodated, and the Tonna Prison's capacity which could accommodate 589, was 496 (The Berlin Senate Department for Justice and Consumer Protection 2015:25). The average occupancy level as at March 2020 was at 81,3% (World Prison Brief, [sa]). The United States Department of States (2018:132) stated categorically that there were no significant human rights concerns regarding detention centre conditions. This seems to be an improvement from when Lehmann (2012:132) indicated in 2012 that physical hard metal shackles restraint continued to be used. He argued at that stage, that the soft restraints should be used as they are more humane and appropriate for mentally ill detainees (Lehmann, 2012:132). The Germany Country Reports on Human Rights practices conducted by the United States Department of States, reports that detention centre conditions generally met the international standards (United States Department of States, 2017a:3).

As outlined earlier, the greater part of prison establishments in Germany encounter delays and problems with transferring severely mentally ill detainees to the prison hospital or a psychiatric hospital to access acute treatment. This results in the detainees being kept at length in security cells in a state of “acute psychosis”. The reason cited for this is the lack of beds (Lehmann, 2012:132). In addition, Seidel et al (2019:6) clearly articulate that remand detainees show a considerably increased prevalence for contemplating suicide, incidences of self-harm, and psychological grief. Although they could be assessed and diagnosed for admission to the prison hospital, remand detainees do not end up being transferred to such hospitals (Lehmann, 2012:132). They languish in remand for many days because of insufficient availability of bed space.

Nationwide statistics for Germany in many respects regarding mental illness are difficult to access (Cuéllar et al., 2015:9; Konrad & Lau, 2010:238; Salize et al., 2007:19). There is no national register to record the number of beds that are allocated for psychiatric services in medical prison wards, there are no national figures to determine the number of medical or therapeutic prison staff, and no determination on staff turnover and vacancy rates of staff allocated to rehabilitation of the mentally ill (Salize et al., 2007:23). Similarly, Sridhar, Cornish and Fazel (2018:2) in their systematic review of prison healthcare expenditure internationally, could not determine the costs that Germany spent on health care of its detainees due to the non-availability of such information. This was also the case as reported by Salize et al (2007:25) who indicate that mental health care costs are unknown. The limited data and research availability will hamper accurate and suitable planning for treatment and therapy of mentally ill detainees (Konrad & Lau, 2010:238).

The German prison system does have a system for detainee grievances, but communicating grievances to authorities is ineffective, because there are no external controls except for the national committee called the “Nationale Stellezur Verhu ¨tungvonFolter” and the European Committee to Prevent Torture, which limits regular, close, and direct external independent observation of prison activities (Lehmann, 2012:133).

Lehmann (2012:133) pointed out that at least 35% of mental patients in German detention facilities were people who had migrated mainly from Turkey and the Soviet Union. He alludes to the fact that language is a barrier when treating such patients, but also cultural practices may hinder effective treatment. Ethno-pharmaceutical knowledge is almost totally non-existent, and if the detainee is released there is very limited availability, if any at all, of transcultural medicine in the community, thus creating loopholes in treatment and care. Ethno-pharmaceutical knowledge is knowledge on the use of traditional medicinal plants for the treatment of various disorders including mental illnesses, and the usage of such medicinal plants for the development of new medicinal drugs. However, such medicinal treatment must be scientifically proven (Reyes-Garcia, 2010:2; Kpobi, Swartz & Omenyo, 2019:250). This may also have implications for the treatment of the mentally ill who may contract COVID-19 (World Health Organization, 2020). Yang (2020:1689) however, cautions against the use of herbal drugs to treat COVID-19.

It is practice, that patients are also used as ward aides to clean the hospital unit of the facility. The subculture (gangs) comes into play where one's health may be at risk for underhand privileges (Salize et al., 2007:43).

There is legal acknowledgement in Section 56 of the Federal Prison Act that prison administration must take responsibility for the mental health of mentally ill detainees and that medical services must be equivalent to that of the general living conditions (Cuéllar et al., 2015:65). One must however be mindful of the fact that German detainees are not included in the public health insurance scheme and therefore are not given the opportunity to be attended to by their own doctor.

From the literature reviewed, it is ascertained that German prisons have made strides into psychiatric care, yet the standard of psychiatric care received in detention is not on a par with that which is received in external psychiatric hospitals. Further to this, although all federal states should have uniform guidelines on mental care, which should include standardised psychiatric evaluations, this is not the case. Therefore, one can deduce that mental care even in German facilities need attention (Cuellar et al., 2018:66).

6.5 NIGERIA

6.5.1 Admission and Assessment

Standing Orders issues by the Nigerian Prison authorities make no mention of psychiatrists or psychologists being part of any medical assessment of new admissions at Nigerian detention facilities. A medical officer will "see" the new admission, or any detainee brought in from another facility within 24 hours of being admitted (Federal Republic of Nigeria, 2011:1443). Also, within these 24 hours, an Admission Board consisting of the medical officer, vocational officer, and the welfare officer, amongst others, will assess the detainee with the intent of informing him/her of the kind of labour for which he/she is certified to be medically fit (physically and mentally) (Federal Republic of Nigeria, 2011:1445). Detainees in certain cases are assessed for fitness to continue labour (Federal Republic of Nigeria, 2011:1529). Agboola et al (2017:10) contend that the mental health of incarcerated detainees is often ignored as routine health screening is not frequently done, causing a situation where many mentally disordered detainees are accommodated together with the general population. This is against the recommendations of corrections medical officers, who indicate that the mentally ill should be treated in capacitated psychiatric hospitals (Agboola et al., 2017:10).

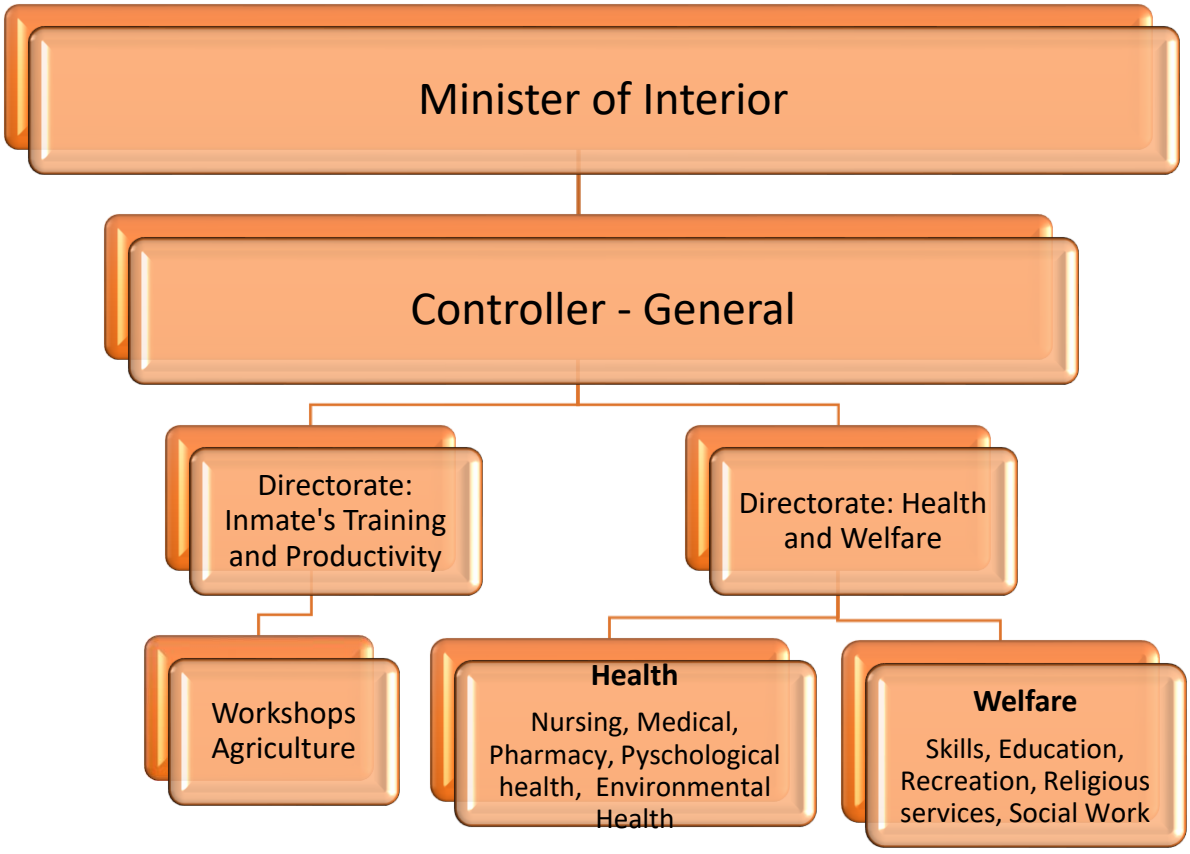
6.5.2 Rehabilitation

The Nigerian Correctional Services refers to reformation and rehabilitation as two separate terms with differing goals. Reformation is a process that requires interventions designed to improve the moral behaviours of an individual with the goal of preventing re-offending (Tanimu, 2010:141). Rehabilitation, on the other hand, refers to the interventions provided to the detainee that would benefit him/her after release so that he/she is able to adapt to the community and reintegrate and resettle into his/her societal roles (Tanimu, 2010:141).

The Nigerian Correctional Services reformation and rehabilitation programmes are organised and as mandated in the Nigerian Correctional Services Act of 2019 as depicted in Figure 7 below (Federal Republic of Nigeria, 2020).

The rehabilitation programmes offered in the Directorate Inmates Training and Productivity (ITP) in Figure 7, train detainees to become productive on correctional services farms and in industries. These activities teach detainees self-sustaining skills and instil in them a positive mental outlook of finding pride in labour. There is also a branch within the Directorate (ITP) called the 'Workshops and Agriculture' section. Detainees are trained on animal husbandry, farming methods, and other agricultural techniques. These programmes empower detainees to consider vocations in these fields after release.

Figure 7: Organisation Structure of the Nigerian Correctional Services



Source: Adapted from Federal Republic of Nigeria, 2020.

The Directorate Health and Welfare as referred to in Figure 7 consists of two branches, i.e. Health services and Welfare services. The Health branch fosters the psychological, physical, and developmental well-being of detainees and administers all correctional clinics and hospitals. The Directorate consists of

doctors, nurses, psychologists, pharmacists, and paramedics. The Welfare branch is responsible for the actual rehabilitation and reform of detainees. The branch consists of personnel who would ensure the following programmes:

- Educational development including adult and remedial education;
- Educational Development Project (similar to South Africa's Higher education), where detainees obtain undergraduate and postgraduate qualifications through correspondence studies;
- Skills training programmes are done in conjunction with the ITP Directorate;
- Religious services;
- Recreational services; and
- Counselling, groupwork, and case work sessions (similar to South Africa's Social Work Services) (Federal Republic of Nigeria, 2020).

The Welfare Branch aims to "reform" the detainee by identifying the reasons for anti-social behaviour, providing self–discovery sessions in order for a resultant positive change in behaviour (Federal Republic of Nigeria, 2020).

Ogunlesi and Ogunwale (2018:36) affirm that there are currently three models of mental healthcare in the Nigerian Correctional System. The most widely used model, is Model A, where mental treatment and care is provided by the corrections clinic in the form of nursing staff, non- psychiatric doctors, and ordinary staff who are used in the clinics to assist the qualified nurses and doctors. Medication in this instance is provided for by the detainee's family or the corrections authorities.

In Model B, mental health is provided for by an external visiting psychiatrist who is supported by a multi-disciplinary team (if available), all of whom are coming from a state health hospital within the respective state. They are supported by the facility nursing staff and other support staff. Medication is subsidised by the corrections service or by relatives of the detainee (Ogunlesi & Ogunwale, 2018:36).

The closest to an ideal situation is depicted in Model C, which in effect, is a prison in-reach programme (Olagunju et al., 2018:82). The visiting psychiatrist (and a multidisciplinary team made up of nurses, clinical psychologists, occupational

therapists, and social workers) come in from a tertiary health institution located in the same area that the detention facility is located. The tertiary health facility also provides a mental health nurse who reports to the prison health clinic on a daily basis, albeit only on weekday mornings. The mental health nurse is assisted by the prison health staff at the prison clinic. Finance for medication is provided by the prison service, or the detainee's relatives are permitted to provide the detainee's medication. This model is hardly applied in Nigeria.

6.5.3 Release

The fairly new Nigerian Correctional Services Act of 2019 has introduced non-custodial sanctions such as "community service, probation, parole, restorative justice and other measures" which include carrying out court orders (Edafe, 2019:95). Literature reviewed does not indicate any major strides with regard to medical parole and the mentally ill, although the Correctional Services Act of 2019 does add a provision for a mental health review board to be established by the Controller-General of the Nigerian Correctional Service in all states. The purpose of this mental health review board is to review cases of mentally disordered detainees (Onyekwere & Ojo, 2019). If the provisions of this and other provisions in relation to treatment of detainees with mental disabilities as contained under Section 24 of the Correctional Services Act of 2019 are efficiently implemented, it will assist in decreasing the numbers of "civil lunatics' within the Nigerian criminal justice system. "Civil lunatics" are detained in the prison asylums although they have not committed any criminal offence (Onyekwere & Ojo, 2019).

The Regulations prior to the Correctional Services Act of 2019 provided for the Minster to take a decision on whether medical release would be granted after receiving a warrant of release, that would be filled in by a medical officer, stating that the mentally ill detainee's health has deteriorated to such an extent that he/she is a risk to him/herself and to other detainees (Federal Republic of Nigeria, 2011:1515). There is no mention made of attending reform programmes for consideration of placement and parole in the new Correctional Services Act of 2019. There is hope that the Nigerian Correctional Services will amend their regulations to be in line with this, and optimistically help pay attention to the

dilemmas faced by authorities of the so called ‘civil lunatics’ and ‘criminal lunatics’, who are often detained in prison without adequate review and mental health treatment. This will hopefully help reduce the burden and capacity gap on the service with respect to the management of these persons (Edafe, 2019:97).

6.5.4 Challenges

Corrections, as a service provider, is functional when it is able to carry out its roles adequately in line with the best practices as guided by international obligations. Besides being documented, the realities on the ground must be evident in the daily operations of incarceration. In addition to this, the infrastructure and governance structure will be pronounced strong and worthwhile if it is able to rehabilitate, reform, and correct detainees of their criminal attitude as well as reintegrate them into society. It will, however, be regarded as weak and ineffective if it cannot carry out its functions adequately (Chukwudi, Marumo & Mothelesi, 2019:12356).

The correctional system in Nigeria, which ideally should be used as a vehicle for reformation and rehabilitation, by providing counselling, rehabilitation programmes, and development of detainees, since the passing of the Nigerian Correctional Services Act of 2019, has remained a breeding ground for toughened criminals who become even more toughened whilst in detention (Chukwudi et al., 2019:12352; Ozuru, 2019:103). The “situation” in Nigerian detention facilities is such that detainees engage in violence, deliberate assaults on staff/ facilities, or riot against administrative gaps on the part of corrections authorities. Ex-detainees relapse to committing crimes such as kidnapping, armed robbery, and hired assassinations because they are not reformed (Abuchi, 2015). This could be attributed to the punitive model still being followed by the Nigerian Correctional Services, whilst policies and procedures still need to be developed in line with the Nigerian Correctional Services’ new strategic direction (Onyekachi, 2016:2). Thus, imprisonment has an ultimate negative effect on human security, as outlined in the Nigerian Government programme of action (Onyekachi, 2016).

The law states that the Nigerian Correctional Services must meet its obligations to provide programmes that will modify negative behaviour amongst detainees (Edafe, 2019:96). Such programmes are to include providing medical, psychological, spiritual, and counselling services for all detainees, including those with violent crimes, yet literature indicates that such efforts are not adequately provided for due to the lack of rehabilitation and correctional equipment in Nigeria's Prisons (Edafe, 2019:96; Onyekachi, 2016:1). Obioha (2011:103) has outlined the initiatives of the Nigerian Government to introduce reform programmes since 1999 and indicates that these may not be sufficient to cater for the detainee population's needs.

Detainees with acute mental disorders who may require more intensive assessment and treatment would be ordered by a court order or an administrative order by a prison medical officer to be transferred to a psychiatric hospital. This is infrequently practised in Nigeria, although it is legislated in the Laws of the Federation of Nigeria (Federal Republic of Nigeria:1990b). Although the Prison Act 9 of 1972 also authorises applicable authorities to transfer a mentally ill detainee to a hospital when conditions in the detention facility are detrimental to the health of an ill detainee, administration issues become an obstacle to a speedy response in transferring the detainee. The poor availability of complete medical services and the dearth of sufficient medical amenities do not allow the Nigerian Correctional Services to fulfill its welfare mandate (Stephens, 2018:241). Agboola et al (2017:14) found that the rate of mental illness at Calabar Prison was 49% and half of those with a mental illness had a co-existing illness, thus finding a significant relationship between a mental illness and at least one comorbid physical illness. The situation is such that even the known psychiatric patients regress because they are not given medication on time, and due to the irregular supply of medication by corrections authorities (National Human Rights Commission, 2014:147). Medical supplies come from the headquarters in the capital cities of each state. Furthermore, because of the dire shortage of medication for the mentally ill, various states have agreements in place with the Federal Psychiatric Hospital for assistance with psychiatric services, however due to the lack of funding to purchase anti-psychotic medication, or vehicles at the detention facility to transport the ill detainee to their facilities (monetary

implications), they do not meet their obligations in the agreements (Agboola et al., 2017:13, Obioha 2011:99).

There is a dearth of medical officers in Nigeria. In some states, as in the Cross River State, which is in the South geopolitical zone of Nigeria, there is only one medical officer in the state. This medical officer sees to the provision of services at two centress with a large detainee population. The responsibilities of a medical officer also include servicing the entire Calabar prison officials at the zonal headquarters in Calabar (Agboola et al., 2017:13). Further to this, with the present Nigerian custodial challenges, the treating of and care for mentally ill detainees is a 'big shoe to fill' and is even called a "mirage" because of the non-existence of acceptable psychiatric services, and the incapability of the corrections clinical staff to detect the signs and symptoms of abnormal behaviours and mental illness among the detainees (Agboola et al., 2017:13; Stephens, 2018:241).

Tanimu (2010:142) argues that although the Nigerian Correctional System aims to reform and rehabilitate "convicts", the strategic direction is not supported by the practical operational realities, and administration is below international standards and best practices. This results in corrections officials and administrators violating many of detainees' human rights. The harsh punishment methods, unsanitary conditions, food and water shortages, extreme overcrowding, scarce medical equipment and treatment, as well as infrastructure deficiencies are but some of the issues that prevent the Nigerian Correctional System from reaching their goals (Agboola et al., 2017:10; Ozuru, 2019:104). This is supported by Tanimu (2010:142) when he refers to the contemporary Nigerian detention facilities as "human cages with no facilities for correction, reformation, and vocational training". All detainee activities in Nigeria are strictly controlled, which according to Obioha (2011:97), treats detainees in a "mentally brutalised manner". The Nigerian reformatory environment is unhealthy, congested, and lacks correctional infrastructure owing to neglect by the Government and corruption (Ozuru, 2019:104). The state, "reformatory" officials, and the public, see detainees as a burden both to the state and to their families. They work long hours under stressful conditions for very low wages. Staff would be lucky if they receive their salaries on time if they receive it all (Chukwuemeka, 2010:119).

Challenges faced by the Nigerian Correctional Services with regard to medical access are many, and these include the interruptions and delays in transporting detainees to psychiatrists for clinical psychiatric assessments, therefore denying them improved and quick access to treatment. Nowhere in the literature does one find the existence of psychiatrists employed in the Nigerian Correctional Services up until 2018. In an audit conducted by the National Human Rights Commission at various detention facilities in 2012, and again in 2014, a sad state of affairs was found, where 29 mentally ill detainees were found in the three centres visited (Keje, Sokoto and Kebbi). There was only one psychologist but no psychiatrist to provide them with any services/programmes/therapy. This dire situation did not change much when Ogunlesi and Ogunwale (2018:36) reported that there was only one psychiatrist in the Nigerian Correctional Services in 2018 and the few trained clinical psychologists and psychiatric nurses were all in administrative posts.

Building relationships with external stakeholders is important. The community plays a vital role, as they can put mechanisms in place to support those that are released. They would be in a better position to even play an advisory role in correction administration, since they would know the historical and criminal background of detainees (Obioha, 2011:103). Faith-based and traditional health organisations can play a central role to advise corrections authorities on human insecurities. Although there are pockets of good projects in Nigeria, such as the project the Federal Government, in partnership with Prisoners Reform had in 2006 which provided 1 Billion Nigerian Nairas for the skilling of the recently released detainees, and detainees with a very short time to release, there is still the absence of an integrated approach to the management of detainees in Nigerian detention facilities (Chukwudi et al., 2019:12364).

It is not just the management that lends itself to corruption, but also the ill-discipline among other corrections staff who involve themselves in corrupt practices, such as aiding and abetting unauthorised substances and smuggling detainees in-and-out of the facility. Guards regularly demand bribes from detainees for various “privileges”. These include receiving visitors, contacting their

families and, in some cases, being allowed outside their cells (Obioha, 2011:99). In their study, Chukwudi et al (2019:12356) found that 77% of the detainees interviewed agreed that corruption encouraged them into committing dangerous crimes. 93% of the detainees indicated that they used corrupt officials and the weak administration as a base to plan for jail escapes, violence, kidnapping, and other dangerous crimes while in incarceration.

The National Human Rights Council has emphasised the issue of overcrowding in Nigerian detention facilities and the many challenges this brings. Overcrowding in Nigeria ranges from as little as 15% in detention facilities, such as Sokoto, to as high as 381% in Katsina Central Prison which had an occupancy of 237 but accommodated 1140 detainees (National Human Rights Commission, 2016:106). A staggering 2400% is also possible in Nigerian facilities (Ozuru, 2019:106). The totaldetainee population for Nigeria is 73 631, and the prison population rate has risen by 19% over three-year period from 2015 to 2018 (Walmsley, 2018b:18). The overcrowding of detention facilities has been demanding not only on the reform staff but also on the wardens to effectively monitor the activities of detainees in their respective cells. Overcrowding results in less time being afforded to corrections staff to carry out their monitoring duties, to check whether the medical personnel, if any, have provided the mentally ill with their medication (Chukwudi et al., 2019:12363).

Funding for health in detention facilities (including mental healthcare) is taken from budgets allocated by the Federal Government through the supervising Ministry of Interior. Funding for Nigeria's detainee population has been on the decline, while the population of detainees has been rising for decades. Inadequate medical facilities, as well as outdated infrastructure, that does not allow for reform and rehabilitation programmes, is cited as a major challenge due to scarce funding (Agboola et al., 2017:13; Ozuru, 2019:105). Despite efforts amongst working groups such as the Prison Reform and Decongestion (established in 2000), the Inter-Ministerial Summit on the State of Remand Detainees (2005), the Presidential Committee on Prison Reform and Rehabilitation (2006), the Presidential Commission on the Reform of the Administration of Justice (2006), and the Committee on the Harmonization of Reports of Presidential Committees

Working on Justice Sector Reform (2007), detention conditions in Nigeria still adversely affect the health of detainees (Opafunso & Adepoju, 2016:166).

The detainees' rights to mental health care are compromised because of the substantial shortages in the supply of medication for detainees with mental illness. Funding is also scarce for hospital admission when the person can no longer be safely cared for in detention (Amnesty International, 2008b:39; Onyekachi, 2016:2). Only 3,3% of the federal budget goes towards mental health in th egenral population (Kalu, 2017:22; Okafor, 2017). Mentally ill detainees are instead contained in designated cells, to supposedly protect them and others from harm, rather than being transferred to hospital for their rightful adequate treatment (Ogunlesi & Ogunwale, 2018:36). In the majority of cases, the mentally ill are not accommodated separately but left to languish with the general detainee population (Stephen & Dudafa, 2016:1; Galanek, 2015:6).

The rate of recidivism in Nigeria in 2005 was 37,3%, while it escalated to 52,4% in 2010, and to 60% in 2015 (Otu, 2015:137). This is an indication that the Nigerian Correctional Services is not able to provide detainees with rehabilitation facilities and the required skills to enable them to work after release. Their idleness and unemployment lead them to resort to criminal activities. This was further confirmed in a study conducted by Chukwudi et al (2019:12356), where 84% of the detainees committed crime after their release. Further to this, the already discussed mal-administration that has been the result of factors ranging from excessive use of imprisonment to punish detainees, overcrowding, weak administrative system, lack of dedicated corrections staff, and complicity, perpetually drive detainees into crime. The shortage of dedicated and honest staff hampers the design and delivery of reformation and rehabilitation programmes, and adds to the challenge of recidivism (Sarkin, 2008:33).

COVID-19 has had a major impact on mental health services in the Nigerian Correctional Services (Ogunwale, Majekodunmi, Ajayi & Abdulmalik, 2020:2). Amongst the many preventative measures taken to curb the spread of the virus, significant limitations were placed on external persons visiting detention facilities. This has had negative implications on mental health services and on the continuity

of mental healthcare. Since Nigerian detention facilitiess do not have psychiatrists of their own, but rely on visiting psychiatrists, mental health assessments were not conducted comprehensively enough as only the nurses' assessments were being documented. This meant that only emergency or provisional treatment for symptoms could be administered to the suspected mentally ill until medication is prescribed by the psychiatrist (Ogunwale et al., 2020:2).

Although not many developments were noted since the changing over from the Nigerian Prison Services to Nigeria Correctional Services in August 2019, one can only hope that a transparent multipronged approach would be taken. The various stakeholders, such as the community, the police, courts, non-governmental organisations, faith-based organisations, traditional health organisations, oversight bodies, and government need to work together to develop strategies that are practical to implement. However, initiatives are being established to start debates on mental awareness such as the Mentally Aware Nigeria Initiative (MANI) and the Nigerian Suicide Hotline (Kalu, 2017:23).

From the various literature reviewed, it would be fitting to deduce that Nigerian Correctional Services have reneged on the detainees' constitutional right to be physically and mentally fit (Amnesty International, 2008b:39). In doing so, the Nigerian corrections system has failed in their mandate to ensure that mentally ill detainees are provided with sufficient staff and the necessary and adequate treatment even when challenges are being experienced. The process of psychological assessment and proper diagnosis of detainees with mental illness is of vital importance. Their challenges with regard to budgets prohibit the modernisation or revamping of old structures to meet international guidelines for the provision of medical facilities, amongst others, and as stated in the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Ozuru, 2019:107 -111).

6.6 USA

6.6.1 Admission and Assessment

Guidelines by the American Psychiatric Association and the National Commission on Correctional Health Care expect that all detainees should be screened within 24 hours (Watson, Hanrahan, Luchins & Lurigio, 2001:478). Yet Denysschen (2018:17) found that most states (51%) screen detainees within a 24-hour period, and 12% screen in less than a 12-hour period. Blevins and Soderstrom (2015:156) found that the screening instruments used varied across the states. They indicate that a vast majority of states utilised consistent and uniformly applied mental health screening instruments, whilst some utilised a behavioural health classification system. This therefore poses a challenge to obtaining accurate information (Blevins & Soderstrom, 2015:156).

After the initial screening, a detainee may be flagged as needing mental health assistance. The guidelines by the American Psychiatric Association, the American Correctional Agency, and the National Commission on Correctional Health Care, also require that detainees be appropriately assessed for mental health issues within seven days upon admission to corrections (Blevins & Soderstrom, 2015:146). The reason that an assessment is conducted is to detect the mental stability of the individual and to identify any possible mental health issues. Once a problem is identified with regard to the individual's mental health, there will be a need to evaluate the need for treatment. Part of this assessment would include identifying detainees who may be a likely source of danger, either to themselves or to other detainees (Adams & Ferrandino, 2008:915).

Assessments, too, vary from state to state, as each state develops their own standards. Detainees are assessed for mood disorders, psychotic disorders, current substance abuse and dependence, suicidal history, personality disorders, and prior psychiatry disorders (Adams & Ferrandino, 2008:915). Some states also assess specifically for mental retardation, sexual history, trauma history, medical history, and substance abuse history. Challenges with efficient diagnosis crop up even at the assessment stage, as there is no validated co-occurring mental illness screening-tool (Montoya, 2018). Al-Rousan et al (2017:5) found that the time between admission and diagnosis of mental illness took too long at the Iowa Department of Corrections. Bipolar disorders mean duration was 11 months; depression, anxiety, post traumatic disorders, and personality disorders took from

21 months to 29 months to diagnose, and the most time was that of schizophrenia, which took 52 months to diagnose.

It is usually expected that assessments should be carried out by doctoral level psychologists or psychiatrists, however, this is not always possible. The formal assessments in most states are conducted by social workers as well as psychologists/clinicians who were at a masters level, or even psychological examiners, social history investigators, nurses, and counselling staff (Blevins & Soderstrom, 2015:149). The length of time of reassessment varied across states, some states reassessed from three months up to one year from when the first assessment was conducted.

After the assessments, identified detainees must be given access to appropriate treatment. Need for treatment is not only identified through screening and assessments but can include other routes such as referrals from custodial staff, administration staff, other professionals, and may include self-referrals (Tamburello & Ferguson, 2016:29). Several types of professionals are responsible for drawing up a treatment plan for mentally ill detainees. In 80% - 88% of the states, it was reported that a behaviour specialist (psychiatrist or psychologist) decides admissibility for treatment services and is ultimately responsible for the drawing up of the treatment plan, which may or may not include the prescribing of medication – this depends on the level of mental illness diagnosed (Blevins & Soderstrom, 2015:146; Denysschen, 2018:18). The degree of treatment offered varies from state to state. This also depends on the type of infrastructure. Some of the American detention facilities were built with a conducive health structure in mind (Blevins & Soderstrom, 2015:146), whilst some structures still resemble those built for incarceration as a punitive measure only.

6.6.2 Rehabilitation

The Federal Bureau of Prisoners administrates its approximately 122 federal prisons as well as 1833 state prisons, 1772 juvenile correctional facilities, and 3134 local jails, with the vision of protecting “public safety by ensuring federal detainees serve their sentence of imprisonment in institutions that are safe,

humane, cost-efficient, and appropriately secure" (United States Department of States, 2019:3). The ultimate aim, like any other correctional system, is to provide the detainee with skills that will assist them become better citizens once released. The goal of decreasing criminality can be motivated through providing detainees with various rehabilitation programmes during incarceration (O'Connor, 2014:49).

Programmes provided to detainees include work, education, vocational training, substance abuse treatment, religious programmes, life skills programmes, and psychological services and counselling; all of which fall under the budgetary programme "Inmate Care and Programs" (United States Department of States, 2019:7). Specialised programmes include the treatment for substance use disorders. Detainees who successfully complete this programme qualify for up to one-year reduction in their sentence. In this regard, Adams and Ferrandino (2008:922) report that pharmacotherapy is often the first choice for authorities for the treatment of mentally ill detainees because it is easier to administer and because of limited space, time, and money required for other types of treatment.

The United States Department of States (2019:8) reported that in 2017, 73% of state facilities disseminated psychotropic drugs to their patients and that an estimated 114,400 detainees nationwide were being treated with psychotropic drugs. This study was conducted on 16 641 detainees living in facilities administered by the Federal Bureau of Prisons (100% of those who were eligible to participate in the programme) (United States Department of States, 2019:8). Funding for psychological services amounted to $73 762 000 in 2017 although the funding for medical services was a substantial $1 178 957 billion. Inmate care and programmes amounted to $ 2 625 439 billion in 2017 (United States Department of States, 2019:19).

Multi-disciplinary teams, which include amongst others, the unit manager, case manager, correctional counsellor, and a unit officer, who have administrative and supervisory authority, are allotted to work with detainees on a permanent basis (United States Department of States, 2019:20). Rehabilitative care to regain or maintain optimal physical and mental health function is provided in all detention

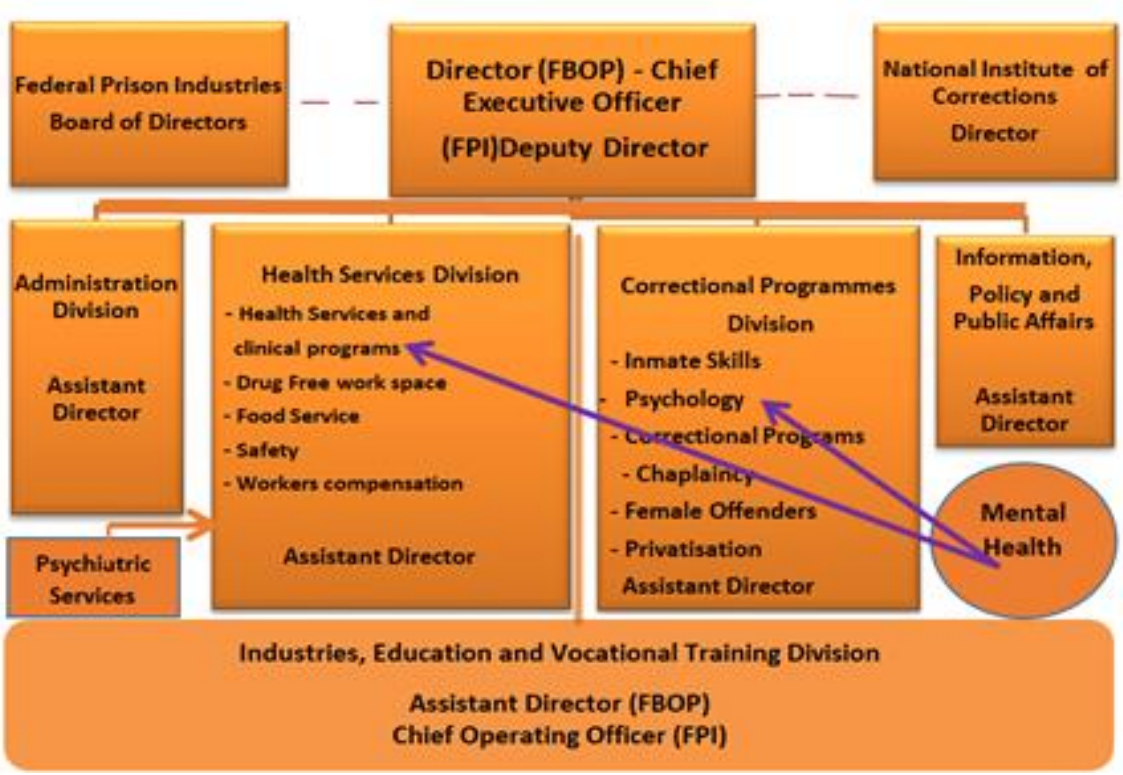
facilities, however, inpatient and forensic mental health is provided in only seven of the federal facilities (United States Department of States, 2019:20).
It is evident from Figure 8 below, that the rehabilitation programmes for the development of detainees fall under the responsibility of the Division Head for Correctional Programmes Division. Part of the rehabilitation (as part of the development of detainees) also occurs at the Federal Prison industries where education and vocational programmes take place. Health care rehabilitation programmes fall under the area of responsibility of the Health Services Division, whilst mental health is a shared responsibility between Health Services and Clinical Programmes (psychiatry) and psychological services, under the responsibility of the Assistant Director: Correctional Programmes Division.

The Federal Bureau of Prisoners has outlined their federal psychiatric services in their programme statement, which indicates that the psychiatric staff will provide mental health care either on an individual basis or as a multi-disciplinary team (United States Department of Justice, 2005:1). Psychiatrists attend directly to detainees who suffer with complex psychiatric conditions which include, but are not limited to, those requiring multiple psychiatric medications, psychiatric illnesses complicated by comorbid conditions, and psychiatric symptoms not responding to usual treatments (United States Department of Justice, 2005:1)

Amongst the duties of the psychiatrist is to consult with, provide training to, and mentor other team members and staff involved in the medical care, mental health care, or supervision of mentally ill detainees, to perform clinical services in an inpatient psychiatric unit, and to co-ordinate the continuity of medical care of the detainee (United States Department of Justice, 2005:1).

Programmes provided in detention facilities cater for fluctuating levels of substance abuse interventions, educational services, and mental health services. Studies demonstrate that a trifling percentage of the incarcerated population obtain these services. In New York City, only 25% of the 78% of detainees (males and females) whose tests proved the use of illegal drugs, have enrolled in drug treatment services (Freudenberg, 2001:215-216).

Figure 8: Organogram of the Rehabilitation Programme in the USA Department of Correctional Services



Source: Adapted from United States Department of Justice, 2005

Detention facilities in America offer in-house treatment (those that stay at the prison mental health unit), and outpatient treatment (those that stay in units other than the mental health unit), such as counselling, group therapy, individual counselling, and/or psychiatric medication (Blevins & Soderstrom, 2015:146). Other services include crisis intervention, acute stabilisation care of mental illness, behavioural health services, individualised therapy, staff-lead group therapy, peer-lead group therapy, peer-lead drug/alcohol treatment, educational or psycho-educational therapy, recreational therapy, pre-release/transitional services, and provisions for referral and admission to licensed community mental health facilities (Blevins & Soderstrom, 2015:151). Mental health programmes are intensive, evidence-based, and use a cognitive-behavioural treatment model. Psychological services staff are an essential part of correctional treatment and are involved in providing the afore-mentioned programmes to mentally ill detainees, in addition to

other general psychological programmes to other detainees. Psychologists also offer their services to the staff (consultation and training). In addition, psychologists provide a complete and detailed psychological appraisal in the form of an evaluation to courts, parole officials, and corrections administrators (United States Department of States, 2019:28-29).

Further to this, the USA has, mainly in facilities administered by the Federal Bureau of Prisons, mental health step-down units which cater for the mentally ill that have been released from the psychiatrist hospital unit (United States Department of States, 2019:33). Mentally ill detainees are not given the necessary treatment in counties or jails because of lack of capacity (Chertoff, Stevenson & Alnuaimat, 2017:25). They are therefore moved to a state psychiatric hospital to receive the necessary treatment and care. State psychiatric establishments are plagued with the problem of insufficient beds, and therefore referred cases are not afforded the treatment they were meant to receive (Chertoff et al., 2017:25).

Adams and Ferrandino (2008:919) indicate that mental health treatment programmes should include protecting mentally ill detainees from certain facets of prison environments. Isolation remains a problem in the majority of detention facilities worldwide, including the USA. Detainees charged with institutional infractions may be sent to isolation cells, which can be intrinsically stressful, and may not be the optimal setting for providing the highest quality care (Tamburello & Ferguson, 2016:30). Adams & Ferrandino (2008:920) indicate that in order for therapy to succeed, one needs to take advantage of specialised environments to reduce harmful experiences that may trigger aggressive behaviour. Programmes that facilitate institutional adjustment, such as the “McNeil Program”, at the McNeil Island Corrections Centre in Washington State, were developed with the goal to return mentally ill detainees to the general population. The focus was on “careful monitoring and counselling on medications”; “psych-educational classes (anger management, chemical dependency) and developing a low-stress milieu”. Subsequent research showed that the occurrences of psychiatric indicators were reduced, and that detainees rated “architecture, freedom of movement, protection

from the stresses of the general population and availability of activities" as positives towards their rehabilitation (Adams & Ferrandino, 2008:920)

6.6.3 Release

The US Department of Justice allows for medical parole in most states. This form of early release is for detainees with terminal illnesses who have been given a prognosis that they will die in six months to a year. This form of parole is not available to detainees of violent crimes. Medical parole has been seen as beneficial to the Department, as it could decrease the rising costs of caring for ill detainees. Other benefits cited by Gavin (2011:250), are that this allows for a dignified death (detainees have a say in their death, last wishes etc). In some states, such as North Carolina, medical parole is only granted to incapacitated detainees who provide proof that they are able to retain their own medical care. Compassionate release or a reduction of sentence is based on medical or mental health conditions. It is also considered for those detainees who suffer with a terminal illness, if they are severely incapacitated, or the elderly (65 or older) with medical conditions (United States Department of States, 2019:23).

6.6.4 Challenges

Challenges are also experienced when it comes to assisting mentally ill detainees with community support. The community support for the mentally ill released detainees is inadequate, resulting in discontinuity of treatment. Greater numbers of detainees return to the corrections system where once again treatment and care is limited. The detainee ends up being recycled between the home and the detention facility (Jones, 2020; Posholi, 2019:19). A staggering 97% of detainees in the USA return to society (Zgoba, Reeves, Tamburello & Debilio, 2020:1). More than two thirds (68%) of persons released from detention will be rearrested within the first three years of release, and 83% will be returned to the criminal justice system within nine years of release (Zgoba et al., 2020:1). It is therefore, imperative to address psychiatric problems in prisons as this would ultimately make a decisive contribution to the community's health and safety (Zgoba et al., 2020:1). Research conducted by Zgoba et al in 2013 at the New Jersey

Department of Corrections studied the records of mentally ill detainees on the Mental Health Special Needs Roster. This roster records all detainees who require treatment because their mental illness is so severe that it hampers their functioning in the detention facility. The study found that the re-arrest, re-conviction, and re-incarceration rates were 52,3%, 38,2%, and 29,8% respectively (Zgoba et al., 2020:4).

The USA has a lack of post-release services (Blevins & Soderstrom, 2015:142). This statement is supported by the findings of a study by Lennox, Senior, King, Hassan, Clayton, Thornicroft and Shaw (2012:71) on severely and chronic mentally ill detainees, where it was found that 30% of convicted detainees did not receive any kind of discharge planning just months prior to their discharge and even of those that were already discharged, only 7% were in contact with a Community Mental Health Team (CMHT).

Tamburello and Ferguson (2016:30) reiterate that while correctional health care providers ought to relieve suffering, improve functioning, and save lives of those with mental illness, this work is rife with challenges.

The challenges experienced in the mental health care offered to detainees are more serious than that of the public health care in the USA (Aufderheide, 2014). These include insufficient professional staff. Blevins and Soderstrom (2015:148) report that the average ratio of staff to detainees as being one psychiatrist for every 1 528 detainees, and one psychologist per 932 detainees which is considered too high for intensive care. The USA, too, experiences an exceptionally low retention rate of corrections health personnel, which adds to the challenges experienced in the health fraternity in corrections. It is indicated by Chafin and Biddle (2013:124), that only 20% of nurses in the USA were still in the employ of the prison over a three-year period. The decision by nurses to leave was due to low salaries being paid to nurses, insufficient contact with patients, and “inappropriate behaviour from prison physicians” (Chafin & Biddle, 2013:125). To make up for the insufficient nurses, authorities increase the scope of the correctional official to include health duties. Because correctional officers are not mental health professionals, nor are they trained to deliver mental health services,

the signs of mental health conditions go unnoticed. It has been shown by neurological studies that signs of various existing mental health conditions may be latent when the detainee is admitted at a new facility (Gonzalez & Connell, 2014:2331), and this requires expertise to detect. Gonzalez and Connell (2014:2331) further add that the conditions under which screening is administered do not favour accurate classification of the mental illness that befalls the detainee.

One in four detainees in New York State detention facilities held in isolation cells is mentally ill. Isolation of detainees escalates the possibility of suicide among the mentally ill (Adams & Ferrandino, 2008:921). Detainees consider being placed in isolation as a punishment and having no-one to support them they found it an avenue for suicide contemplation/ideation, especially if the segregation was prolonged. Fellner (2006:143) and Posholi (2019:19) indicate that placing the detainee in segregation flouts human rights provisions. Mental health professionals working in corrections perform their duties in establishments managed by security officials in conformity to procedures that are not in favour of, nor designed for, the mentally ill (Blevins & Soderstrom, 2015:145; Fellner, 2006:143).

Furthermore, there are territorial conflicts among the security personnel, administrators, and the mental health care staff, and each unit tries to ensure their responsibilities are fulfilled (Brivik, 2005:43). Correctional officers and administrators have a responsibility regarding the safe and orderly operational requirements of jails and prisons, and scheduled detainee movements or unscheduled lockdowns usually take precedence over clinical and rehabilitative activities. The punitive and uncomfortable, isolated confinement can aggravate psychiatric breakdowns (Tamburello & Ferguson, 2016:30). Because isolation/segregation cells are structured in such a way as to promote punishment, there is no space for the much-needed private counselling, group therapy, or structured activities. One can safely say that the role of health professionals as regards those mentally ill in isolation, is reduced to that of merely the issuing of medicines.

Other than the exacerbation of mental illness in prisons and jails, Adams and Ferrandino (2008:914) emphasise the challenge of comorbidities of mentally ill detainees. Blevins and Soderstrom (2015:156) believe that mentally ill detainees are likelier to also suffer from drug or alcohol abuse disorders which results in these conditions becoming more complex to treat, as different disorders may require different treatment strategies.

Further to this, some states lack document control and record-keeping. Thus, tracking of whether detainees receive the care or treatment to which they were entitled becomes a problem. Effective treatment and care for mentally ill individuals can be provided only if it is properly identified, correctly diagnosed, and proper systems of evaluation are in place (Posholi, 2019:25). It is therefore important that this aspect of proper documentation and record-keeping is addressed by the corrections authorities.

Mentally ill detainees are also looked down upon by correctional officials. In a study conducted in the USA in 1989, security personnel professed that detainees with mental illness possessed poor reasoning, they could not be understood easily, and therefore were regarded as less important than those without mental illness (Posholi, 2019:25).

McCarthy (2018) quotes high overcrowding rates in the USA, with as many as 18 states reporting they were overcrowded in 2018. Alabama reported up to 180% capacity in 2018 (Faife, 2019). The USA, however, has been able to reduce overcrowding from 103,9% in 2018 (McCarthy, 2018) to 99,8% in 2019 (World Prison Brief, 2020d). Researchers (Adams & Ferrandino, 2008:913; Al-Rousan et al., 2017:7) attribute overcrowding in the last decade in USA detention facilities to the de-institutionalisation process that started in the 1970s whilst Freudenberg (2001:217) adds to this, indicating that criminal justice strategies such as compulsory “minimum sentences and the war on drugs” is also reason for the USA’s large detainee populations. It was expected that with this process, the mentally ill would get the treatment and care that they deserve in the communities, however, the government did not establish sufficient community-based treatment facilities and service points (Blevins & Soderstrom, 2015:143). Many mental

institutions closed down, and the mentally ill, not being treated or cared for, turned to criminality and ended up in the USA corrections system. Currently, the number of severely mentally ill detainees incarcerated in prison hospitals is ten times more than those being treated in state hospitals (Al-Rousan et al., 2017:1). Once in detention, they are accommodated with the general population. This is a cause for concern, as the mentally ill may elicit "disorderly behaviour" from other detainees who may not know how to react to a mentally ill detainee. Mentally ill detainees are more prone to harassment by other detainees, and are at a higher risk for victimisation and possible assaults by sexual predators. This becomes a more stressful environment for correctional officials (Blevins & Soderstrom, 2015:143). It must also be borne in mind that the mentally ill are also potential aggressors who may attack correctional officials and other detainees (Adams & Ferrandino, 2008:917). Such attacks may aggravate existing mental illnesses; which findings are also supported by Al-Rousan et al (2017:6).

Golembeski and Fullilove (2005:1702) believe that rehabilitation, which ideally should have improved the health of detainees, does not work in a system that is so overcrowded. Fellner (2006:144) supports this, by indicating that overcrowding results in prisons being incapable of delivering sufficient psychiatric treatment and psychiatric programmes. Providing such treatment and programmes within the confines of the rules limit a rehabilitative culture. Many detainees re-enter the community just as uneducated as when they got in, lacking vocational skills, and in some cases, with more medical problems than when they went in. Many find it difficult to cope with their substance abuse, physical or mental disabilities (Seigafo, 2017:183-184).

As literature has shown, mentally ill detainees stay longer in detention than other detainees. This therefore means that they also cost significantly more than the regular detainee. Mental health services in U.S federal facilities, is funded, implemented, and overseen by the Federal Government. State-run prison health care is funded by state taxes. It is evident that spending on health care varies from state to state, which results in the uneven provision of correctional mental health care (Turner, 2008:417). In Washington State prisons in 2009, the most seriously mentally ill detainees cost $101 653 each, as compared to approximately

$30 000 per year for other detainees (Torrey et al., 2014:17). Mental illness is the primary reason for high clinical expenditures in corrections facilities in the USA (Al-Rousan et al., 2017:7). Medicare does not pay for detainees' health care and therefore the costs are borne by the Department of Corrections (Gavin, 2011:249). This creates a concern due to the unprecedented increase in incarceration rates in the USA.

Clearly, providing medical mental care to detainees, and guaranteeing the sustaining of care and treatment after release, are logistically complex and costly (Al-Rousan et al., 2017:1; Shalev, Chiasson, Dobkin & Lee, 2011:693). The USA, being the global leader with the largest incarcerated population, with over 2 million detainees, and an estimated 650 000 prison releases, and nine million jail releases each year, faces a major health crisis if mental illness goes undetected and untreated. Such figures pose a great challenge to the capability of the USA's mental health system to provide the necessary and obligatory access to treatment and care required by the 14% to 31% of American detainees who have a mental illness, and approximately two-thirds of whom who may not have had the opportunity to receive treatment in detention (Draine et al., 2010:458; Turner, 2008:416).

Most USA detention facilities do not provide sufficient programmes to address the educational needs of the incarcerated population, nor do they provide sufficient opportunities for developing job skills, or the necessary interventions to treat drug and alcohol abuse. This therefore leaves the community in a situation where they are compelled to partner with private institutions to deal with the physical, emotional, psychosocial problems of returning mentally ill detainees (Golembeski & Fullilove, 2005:1702).

The mentally ill, being a vulnerable group, should be protected, yet they are subjected to ill-treatment by corrections officials and other corrections personnel, and are abused by other detainees (Vallas, 2016:11). Only a third of state detainees who qualify to receive mental health treatment are given such treatment after being admitted (Turner, 2008:416). Rather than utilising external institutions

to treat and care for their mentally ill, the US treats them in prisons (Turner, 2008:418).

6.7 CONCLUSION

Detainees with mental health problems benefit from good basic mental and health care, and the mental well-being of any detainee can deteriorate if his or her needs are not met (Durcan & Zwemstra, 2014:87). It can, however, be deduced from the above discussions that there are serious challenges facing the rehabilitation of detainees in the USA, and more especially in the management of mentally ill detainees. The treatment needs of the detainee, the resources available for treatment, and the previously mentioned resource gap, have considerable negative effects on the administrative and rehabilitative management of mentally ill detainees. It is also clear that there is a disjuncture between what is legally documented, and the realities of operations. Corrections mental health services should be based on the health needs of detainees. This might require more intensive and integrated multidisciplinary planning to ensure that mental health services are based on the mental health needs of the detainee (Durcan & Zwemstra, 2014:87). A feint balancing act is required by correctional officials to maintain order and to rehabilitate detainees, while trying not to punish mentally ill detainees for conduct that is beyond their control (Adams & Ferrandino, 2008:917).

CHAPTER 7

FINDINGS AND RECOMMENDATIONS

7.1 INTRODUCTION

This study aimed to conduct a comparative study on the the management of mentally ill detainees in the correctional system of four countries, namely, South Africa, Nigeria, Germany, and the United States of America.

Objective 1 was to understand and compare legislations of South Africa, Nigeria, Germany, and the United States of America mandating corrections to commit a mentally ill person under its care. All countries studied have clear mandates and guidance both internationally, regionally, and nationally to commit mentally ill persons under its care. Of the four countries it must be indicated that Nigeria lagged behind in developing policies or legislation prior to 2019. The newly Correctional Services Act of 2019 was approved and the “corrections” system waits a new era in the care and treatment of mentally ill detainees.

Objective 2 was to understanding the role of corrections in the CJS. Corrections, being one partner in the CJS, is entrusted to fulfil the mandate of the court for the imprisonment of detainees, thus also providing for the essential management, rehabilitation, and reintegration of all detainees in its care.

Objective 3 was to understand the management of mentally ill detainees in corrections. People who end up in detention usually are already unhealthy and most will encounter other unhealthy detainees in congested facilities. These detainees are in constant jeopardy of adding stress to their mental condition and well-being, which is exacerbated by factors such as overcrowding (Department of Correctional Services, 2000:2).

Objective 4 was to understand the challenges facing corrections in the management of mentally ill detainees. The literature reviewed indicates that corrections facilities are no place for mentally ill detainees because of the

challenges experienced with regard to the attainability and ease of access to mental health care in detention facilities.

Objective 5 includes proposing a model for South Africa for the management of mentally ill detainees in a correctional system after having explored the management of the mentally ill in all four countries.

From the literature reviewed, it has been made clear that the management of the mentally ill in corrections has been challenging to the corrections systems. Taking the developments into consideration, one can outline a common thread in all countries that have been studied, with regard to the early handling of the "insane" and the progressions up to the state where corrections and indeed the Government are adopting a more modern approach. Documentation has been made available to policy makers; to those who want to join corrections because of their belief in the rehabilitation of detainees; to the public; and even to researchers; indicating the improved management of the mentally ill in the corrections systems of the world. These improvements have been extensively discussed, yet there are shortcomings in implementing International and National Guidelines, legislations and policies.

A summary of the findings will now be given, and recommendations will be provided on the management of mentally ill detainees.

7.2 FINDINGS

7.2.1 Understanding and comparing Legislation Governing Mentally Ill Detainees in Corrections

Mental health legislation is crucial and indispensable. Without it, mentally ill persons will not be heard nor seen as they will languish in the background of any society. Institutions and departments managing mentally ill persons (including corrections systems) need a legal framework that will encapsulate fundamentally key matters that have a bearing on the discipline of mental illness. Legislation to provide this guidance must exist, but that in itself will not automatically provide an

assurance that the human rights of detainees with mental disorders will be protected.

Table 15 below, indicates that all four of the countries studied have mental health legislation in line with Universal Guidelines, as well as corrections legislation pertaining to mentally ill detainees, albeit that Nigeria's legislation pertaining to the care and treatment of mentally ill detainees was approved in 2019 with the enactment of the Correctional services Act, 2019.

Sufficient legislation exists in South Africa that incorporates the elements discussed above. South Africa's National Mental Health Care Act 17 of 2002 is the country's overarching mental health law which incorporates the management of the mentally ill in the CJS, and the corrections system to provide mental health care, treatment, and rehabilitation of mentally ill "prisoners" (its detainees). Legislation in South Africa includes the Criminal Procedure Act 51 of 1977 (criminal responsibility, defence of criminal responsibility), as well as the Correctional Services Act 111 of 1998 as amended (management, care, treatment and rehabilitation of mentally ill detainees under the care of Correctional Services).

Nigeria, in contrast, has had no updated Mental Health legislation as there is no mention made of mental health neither in the National Health Act 8 of 2014 nor in the National Health Policy of 2016. The Criminal Code of 1990 and the Federal Provisions Act of 1960 governs the plea of insanity in the non-Muslim Northern States of Nigeria. The Criminal Procedure Act of 1990 and the Criminal Procedure Code of 1960 governs the insanity defence in the Southern states of Nigeria. In addition to this, the Sharia Penal Law and the Sharia Criminal Procedure Code Law 18 of 2000, applicable to the Northern states practising Islam, points to another reason a person will be considered not guilty by insanity. The belief that the "Magical or Sacred apprehends insanity through a supernatural and divine scope" alludes to the helplessness of "possessed" persons (Tzeferakos & Douzenis, 2017). The Nigerian Prison Act of 1972 addresses the "insanity of prisoners", however the review of this Act resulted in the passing of the Correctional Services Act of 2019, which introduces the Mental Health Review Board to be implemented in all states. This would hopefully address the issues

mentioned above, and will result in a decrease in the numbers of civil lunatics who are kept in Nigerian detention facilities (Onyekwere & Ojo, 2019).

The USA has sufficient legislation governing mental health. This includes the Mental Health Services Act of 1980; the Mental Health and Mental Retardation Facilities Act of 1980; Americans with Disabilities Act of 1990; and the Mental Parity and Addiction Equity Act of 2008; the Patient Protection and Affordable Care Act of 2010; amongst others. Statutes for mental health care in the CJS and prisons are plentiful. They are realised in the United States Code (criminal capacity, insanity defence); the Insanity Defense Reform Act of 1984 (management of mentally ill detainees); MIOTCRA (grants for the mentally ill); Mental Health Reform Act of 2015; as well as the Mental Health and Safe Communities Act of 2015 (which emphasised the use of corrections programmes as an integrated approach to managing mental health problems); the 21st Century Cures Act (pre-mandatory pre-release assessments and diversion programmes for the mentally ill); the standards and guidelines of the American Correctional Association; and the National Commission on Correctional Health Care; amongst others (Human Rights Watch, 2009).

Germany has a distinct legal framework to regulate mental health law in the CJS as well as in corrections, such as the German Criminal Code (criminal capacity, insanity as a mitigation factor, obligation to attend determinate or indeterminate treatment, compulsory detention in special detoxification units); German Code of Criminal Procedure (1950, amended 2014) which provides the court procedures of mentally ill amongst others; the Mental Health Care Code; and the Federal Prison Act of 1976; however, there is no countrywide mental health law. Each state is responsible for developing its own mental health laws. Being guided by the national guidelines, every German state has devised its own standards and processes for the selecting and placing of detainees with personality disorders into social therapeutic treatment programmes (Trestman et al., 2007:231). The Federal Prison Act of 1976 is regarded as one of the most progressive laws in corrections because it allows detainees a say in their rehabilitation path by developing a sentence plan in collaboration with the corrections officials, and in so doing, the detainee also considers his/her health care issues (mental or physical).

Further to this, the Federal Prison Act of 1976 ensures therapy orders given to former forensic patients (reform parolees) are regarded seriously in that they must still continue their therapy and care as forensic outpatients.

Criminal Law, legislations, and regulations applicable to the management of mental illness in the South African CJS, and in particular the correctional system, applies nationwide. Nigeria has their Federal Penal Code, but regulation development was left entirely to each region. German Criminal Law regulating criminal responsibility applies across the nation, whereas federal law standardises the procedural aspects; however, each state is autonomous in developing and implementing their own state laws (Salize & Dreßing, 2005:37). In the USA, CJS legislation is in the form of their Federal Criminal Code, but each state also develops their own state laws. Legislation on mental health is vital to "complement" and strengthen mental health policy and does not in any way take the place of policy (World Health Organization, 2003:3-10). Therefore, policy is imperative to advance the rehabilitation and reintegration goals of corrections systems across the globe. For the corrections system specifically, policy must be aligned to legislation, and must address amongst others, the human rights of mentally ill detainees, access to and the provision of mental health treatment and care, the humane management of the mentally ill, providing of high quality care in line with other institutions, the rehabilitation of detainees, reintegrating detainees into community, and support during aftercare (World Health Organization, 2003:11). South Africa has an overarching policy framework in the form of the White Paper in Corrections, 2005; the USA's overarching guidance is in the form of Guidelines by the American Psychiatric Association, which makes provision for each state to develop their own regulations; whilst Germany's Civil Code Laws provide for states to draft their own state regulations. Regulations for the management of the mentally ill in Nigerian detention facilities do not exist.

Table 14: Legislation Governing Mental Health

	South Africa	Nigeria	Germany	USA
Corrections legislation pertaining to mentally ill detainees	Yes	No prior to the Correctional Services Act, 2019 Yes	Yes	Yes
Mental Health Legislation in line with Universal Guidelines	Yes	Yes	Yes	Yes
National Mental Health Legislation	Yes	No Responsibility of each state	No Responsibility of each state	Yes
CJS legislation (Criminal law, Criminal Procedure legislating mentally ill)	Yes Nationwide	Yes Procedure - Regional	Yes Procedure – each state decides	Yes Procedure – each state decides

7.2.2 Understanding the Role of Corrections in the Criminal Justice Systems

Among the various objectives of any CJS is to keep the community, detainees, and personnel safe (Stephens, 2018:14). One of the ways to do this is to keep the "insane" and the mentally ill out of the community, and in countries like Nigeria, the most "convenient" place to keep the mentally ill is in detention. However, in Germany, the German prison system is rehabilitation-centred and the mentally ill are not sent to prison but to rehabilitation units or psychiatric prison hospitals for treatment before serving their sentences. This is done through hospital orders (Subramanian & Shames, 2013). Germany believes that receiving a prison sentence is punishment in itself, and therefore detainees' human dignity should not be compromised in the process, and in so doing, detainees will be given proper housing and be treated well (York, 2019). Treating detainees humanely

and with respect for their human dignity is very important to the German criminal justice system, and correctional officers and corrections management are required to support detainees to improve themselves. By contrast, the Nigerian and the American corrections system is documented as being punitive. Consequently, the mentally ill are warehoused in Nigeria and not much consideration nor budget is given to their mental health needs. The detention facilities in the USA (jails, state prisons, and federal prisons) too are regarded as some of the largest institutions ever to accommodate the mentally ill, with efforts in place to provide care and treatment to the mentally ill, albeit with varying standards throughout the various states. The South African corrections system is rehabilitation-centred. South African correctional facilities have programmes in place to address the needs of the mentally ill, however, these institutions, managed by the Department of Correctional Services, do not have the necessary infrastructure nor capability to provide proper care and treatment of mentally ill detainees, as found by the Inspecting Judge of Correctional Services (Ellis, 2019).

7.2.3 Understanding the management of mentally ill detainees in corrections

7.2.3.1 Organisational Comparison

As depicted in Table 14, South Africa has a mixed legal system of both Civil Law and Common Law which has resulted in the criminal procedure system following an adversarial approach. South Africa is a Constitutional democracy that resulted in a name change from the Department of Prisoners, to the Department of Correctional Services in 1991. This, too, indicated a new focus on the rehabilitation and reintegration of detainees, much in the same way of Nigeria and Germany (resocialisation and rehabilitation). Nigeria, too, follows an adversarial system which is however embedded in four sources of law, namely, Sharia Law (Islamic Law); Common Law; Customary Law; and English Law prosecution. Nigeria's change from the Nigerian Prison Service to Nigerian Correctional Services came in 2019, which hopefully will usher in the much needed rehabilitation and reintegration of detainees that is promised. Germany, which has been operating as a Democratic Republic since 1949, approaches its criminal

procedure as inquisitorial within a Civil Law legal system, whilst the USA adopts an adversarial approach within a Common Law legal system, with the exception of the state of Louisiana which follows Civil Law.

Table 15: Organisational Comparison

	South Africa	Nigeria	Germany	USA
Authority Ministry	Ministry of Justice and Correctional Services	Ministry of Internal Affairs	State (Land) Ministries of Justice,	Department of Justice
Sources of law	Civil Law and Common Law	Sharia Law (Islam states in Northern Nigeria), Common Law, Customary Law and English Law	Civil Law	Common Law except the State of Louisiana
Corrections/Prison Authority	Department of Correctional Services	Nigerian Correctional Service	Leander (Ministries of Justice) Prison administrations of the 16 states (Leander)	Federal Bureau of Prisons and State and Local Authorities
Jurisdiction	National 6 regional commands	Federal 8 Zonal commands	Federal 16 States	Federal 52 States Local
Criminal Procedure system	Adversarial approach	Adversarial approach	Inquisitorial	Adversarial approach

Common challenges highlighted in the literature reviewed beg to answer the question as to whether correctional systems are equipped to manage mentally ill detainees.

It has been established from the literature reviewed that mental illness is more prevalent in the corrections system than in the general population in three of the countries studied, namely, Nigeria, Germany, and the USA. South Africa's statistics indicate that the prevalence of mental illness in corrections (from 22,5% of up to 33%) is similar to that of those in the general population (33%). In Nigeria, the prevalence of those detained is from 20,8% up to 87%, whilst that of the general population is documented at 12%. The general population in the USA has a 34,2% prevalence whilst that of the incarcerated population is 19,12% in federal facilities and a prevalence of up to 80% amongst the incarcerated youth. The prevalence of mental illness is higher in the incarcerated population in Germany (from 26,2% up to 43%) when compared to the overall population suffering with a mental illness which is from 17% - 19%.

Studies on the prevalence of mental illness among detainees in the two African countries, namely South Africa and Nigeria, are quite high, and this is in keeping with high prevalence rates among detainees in the developed countries (the USA and Germany). The conclusion is, therefore, that the rate of mental illness among detainees in both developing countries and developed countries is high (Durcan & Zwemstra, 2014:88; Fatoye et al., 2006).

Germany has been in the forefront regarding the management of mentally ill detainees, as their focus is on independence after release, and for the proper treatment of mentally ill detainees, by equipping their detention facilities with autonomous psychiatric departments. These psychiatric departments would consist of special units to deal with specific mental illnesses. Such facilities do not exist in Nigeria. South Africa also does not have psychiatric facilities in corrections to assess the criminal capacity of detainees (Mars, Ramlall & Kaliski, 2012:244). The USA Federal facilities do cater for psychiatric services in their facilities for the purpose of in-house treatment, and outpatient treatment, as well as step down units to cater for those who are close to the end of their treatment (Blevins & Soderstrom, 2015:146).

Although the initial mental health screening in Germany is not conducted by experts in the field of psychiatry, extensive assessments to determine mental

illness are conducted by a multi-disciplinary team that includes a psychiatrist, psychologist, social worker, behavioural therapist, and a lawyer or judge. Reliable assessment tools which are custom-built for the different areas of mental health are used (Trestman et al., 2007:232). As a country, there was no provision made by the then Nigerian Prison Services for assessments of admissions for mental illness, nor for the rehabilitation of the mentally ill, or for their medical treatment (Ude, 2015:5). The USA indicates that the ideal is for assessments to be conducted by psychiatrists, however the multidisciplinary team that conducts the assessments consists of social workers, psychologists/clinicians who were at a master's level, or even psychological examiners, social history investigators, nurses, and counselling staff (Blevins & Soderstrom, 2015:149). Guidelines from the American Correctional agency are provided, but each state develops their own standards for screening and assessment (Montoya, 2018). In South Africa, a multidisciplinary Case Assessment Team uses the risk-need-responsivity model, which includes a psychologist, and all other officials involved in the rehabilitation of the detainee (social work services, spiritual care services, health care services, security, offender profiling, formal education, skills development, sports, arts, culture, and social reintegration) (Frantz, 2017:13).

Nigeria has failed in its management of mentally ill detainees. Nigeria's corrections system has focused on keeping the mentally ill away from the public in order to keep the public safe. It does not believe that the wellbeing and safety of mentally ill detainees is just as significant (Ude, 2015:5). Another dimension that adds to the challenges in Nigeria's corrections system, is the issue of many looking to witchdoctors for solutions to their mental problems. The testimony of witchdoctors is not accepted in courts, placing the detainee at a disadvantage (Abdalla-Filho & Bertolote, 2006:59). There was a complete lack of provision for treatment of people detained for mental health issues because of the scarcity of medical practitioners and psychiatrists (Ude, 2015:5). This therefore means that comprehensive and exhaustive treatment offered in detention facilities was virtually impossible in Nigeria.

7.2.4 Understanding the challenges facing corrections in the management of mentally ill detainees.

It has been found that South Africa and Nigeria have high levels of overcrowding as can be seen in Table 16. South Africa's overcrowding was recorded at 37% and Nigeria's overcrowding can reach up to 2 400% (Ozuru, 2019:106). The USA and Germany figures do not indicate overcrowding nationally. Germany's detention facilities are operating only at 87,5% of the full capacity that their facilities are meant to occupy. The USA, on the other hand, has been able to reduce their overcrowding from 103,9% in 2018 to 99,8% in 2018 (World Prison Brief, 2020d). Although the national figures do not indicate overcrowding, many states still operate at over 100% capacity.

The USA, with a detainee population of over 2,1 million and an incarceration rate of 655 per 100 000 is the highest globally, and when compared to the four countries in this study. Second to this is South Africa, with a detainee population of 161 202 (12th most globally) and an incarceration rate of 279 per 100 000 making it the 40th highest incarceration rate in the world and the most populated in Africa (World Prison Brief, 2020d). This is followed by Nigeria, with a detainee population of 67 227 (26th most globally and 5th most in the continent), and finally by Germany with a detainee population of 63 851. However, Germany's incarceration rate of 77 per 100 000 places it at 169th globally and 42nd continentally. Nigeria, with an incarceration rate of 33 per 100 000 is placed 212th globally and 7th lowest in the African continent (World Prison Brief, 2020d).

Remand detainees make up a proportionate number of the detained population in all four countries studied and contributes to the high prevalence of mental illness in corrections. In all four countries, mental illness amongst its remand detainee population is above 30%. South Africa's remand detainee population stands at 29% with a mental illness prevalence of 32,8% (Department of Correctional Services, 2019a:46). Nigeria's remand population is 73% with a 56,6% mental illness rate, whilst the remand detainee population is only 20% in Germany (World Prison Brief, 2020d). Germany's remand population has up to 43% prevalence of

mental illness (Seidel et al., 2019:6). The USA detainee population consists of 23,4% remand detainees with a 36% mental illness prevalence (World Prison Brief, 2020d). The contributory factor to these high prevalence rates of mental illness amongst remand detainees are the long periods awaiting trial. Prolonged exposure to an overcrowded environment and poor conditions of incarceration can lead to a mental breakdown (Agboola et al., 2017: 10). This in turn poses a major risk to the development of mental disorders (Salize et al., 2007:55). Further to this, it has been established that correctional facilities are not idyllic places to care for mentally ill detainees.

Table 16: Detainee Population

	South Africa	Nigeria	Germany	USA
Deatinee Population as at November 2018	161 202	67 227	63851	2 121 600
Global Ranking	12th	26th	29th	1st
Continent Ranking	1st	5th	6th	1st
Incarceration Rate per 100 000	279	33	77	655
Global Ranking	40th	212th	169th	1st
Continent Ranking	5th	46th	42nd	1st
No of detention facilities	243	240	179	4455
Occupancy level	137%	146,8%	87,5%	99,8%
Percentage of remand detainees	29%	73%	23,4%	20,0%

Source: Adapted from World Prison Brief, 2020d: Institute for Crime and Justice Policy Research for Germany, Nigeria and USA. South Africa: Daily Unlock: DCS South Africa

The failed de-institutionalisation processes and the conditions of incarceration in countries like South Africa, Nigeria, and the USA have been grounds for human rights abuses. The finding is that that mentally ill detainees spend longer periods in detention than the general population which has greatly contributed to the high numbers of mentally ill in corrections. The situation requires well thought out strategies to manage the mentally ill in detention, in order to realise the ultimate

aims of both protecting society and rehabilitating the detainee, to such an extent that he/she is able to function independently after release. In the efforts of trying to prepare detainees for reintegration into society, Germany allows detainees to decide on their sentence plans, what to wear and what should their meals consist of (Subramanian & Shames, 2013:12), whereas in South Africa, Nigeria, and the USA, what to wear (usually a uniform), when to wake up, and what to eat is determined by the corrections authorities.

Rehabilitation programmes are given priority in Germany where interventions aim to ensure that detainees are treated humanely, whilst it has lost its importance in the USA, with the focus on punishment as opposed to rehabilitation (Subramanian & Shames, 2013:12). Rehabilitation, up till the mid-1970s, worked in the USA, but in retrospect, the authorities took a turn towards incapacitation and retribution as a reason for incarceration (Phelps, 2011:33). Rehabilitation is not a priority in Nigeria (Edafe, 2019:96), and great improvements have been seen in South Africa, although much criticism is levelled against such rehabilitation programmes not being effective due to the highlighted challenges (Department of Correctional Services, 2019a:28). Further to this, the German corrections system has mastered the rehabilitation efforts of those who are mentally ill, yet recidivism rates are high among the overall detainee population, as well as among the mentally ill in all countries where information could be obtained.

Morgan et al (2012:38-39) further indicate that psychiatric rehabilitation includes various social and educational services as well as supportive community interventions. There are a variety of services available globally for psychiatric mental illness such as skills training, vocational and social rehabilitation, family, community support, intensive case management, supportive accommodation, and substance abuse treatment which have facilitated positive outcomes. Vocational rehabilitation is, according to Rössler (2006:152), central to rehabilitation because it galvanises self-esteem and leads towards independence and is a positive move towards the detainee's reintegration into their community. Morgan et al (2012:38) cautions that if intervention programmes are unidirectional and not multifaceted, they run the risk of not resulting in decreased psychopathology or psychosocial rehabilitation; thereby defeating the aim of criminal justice systems, which is to

reduce criminality. Programmes especially developed with the intention to meet the psychiatric needs of mentally ill detainees have shown to significantly decrease returning to a criminal life (Morgan et al., 2012:38). It is evident in all four countries studied, that rehabilitation programmes are a shared responsibility of psychological services and health services. Moreover, in Nigeria and the USA, psychology finds a home under correctional programmes. In addition, the USA allocates multidisciplinary teams to work with the mentally ill on a permanent basis. However, the clinical aspect of mental illness is specifically the responsibility of a psychiatrist. In this regard, the Nigerian detention facilities do not have a structure that caters for the post of a psychiatrist in their facilities, whereas there is such a post in South Africa, USA, and Germany. In view of the fact that these specialists are difficult to attract and retain, however, South Africa does not currently employ a psychiatrist. Professionals in the field of psychiatry are scarce in the countries studied, however, Germany's autonomous psychiatric departments are equipped with psychiatrists. Additionally, Germany has made it a legal requirement for all psychologists' qualifications to include legal psychology or a licence to practice psychotherapy. This is done so that psychologists are also knowledgeable on caring appropriately, as regards an detainee's specific offending conduct and their mental disorder, in facilities that do not have psychiatric departments. Nurses dealing with the mentally ill must, as a legal requirement, undergo additional qualification to be able to do this (Subramanian & Shames, 2013:14).

It has been established that South Africa does not have a reliable system to record recidivism rates (Lekalakala, 2016:143). However, the two studies quoted in this research indicate that the Durban Westville Correctional Facility in KwaZulu Natal, South Africa, has a recidivism rate of 21,7%, and a study by Morgan and Del Fabbro (2014:2) indicate that the recidivism rate was 44,4% for state patients being treated at the Sterkfontein Psychiatric hospital. The recidivism rate in Nigeria, according to Abrifor, Atere and Muoghalu (2012), cited in Otu (2015:137), progressively increased from 44% in 2008 to 52,4% in 2010, and to 60% in 2012. Germany's recidivism rate was 35,9% (Salize et al., 2007:157) and that of the USA varied from 68% within three years of release, up to 69% within six years, and even to a staggering 83% within nine years (Alper, Durose & Markman,

2018:1). This therefore supports the statement made by Han (2016:3) that mentally ill detainees are more likely to be re-apprehended. This could be attributed to the illness not having been treated, or that the appropriate treatment was not administered, their non-acceptance into the community, and the non-availability of treatment within the communities that they were released into. All of which give rise to the recycling of mentally ill detainees within corrections. High rates of recidivism means more crimes, more victims, and more pressure on the CJS, and added pressure on the coffers of the country. Porporino (2020:16) is of the opinion that mentally ill detainees are at less of a risk to relapse into crime, yet research findings point in the other direction. The increased and high rate of recidivism ultimately suggests that the interventions provided by the corrections systems were ineffective, and failed firstly, in their aim of rehabilitating the mentally ill to reach a level of living without any support, and secondly, of reintegrating mentally ill persons into society.

There are mixed findings on whether mentally ill detainees are incarcerated because they have been associated with serious crimes involving violence and antisocial behaviour. In South Africa and in Germany, all studies referred to, indicate that this is the case, however a different picture is illustrated for Nigeria, where a third of the mentally ill detainees languishing in detention facilities did not commit any crime. The majority of the mentally ill in the USA, have been associated with low level non-violent transgressions, and are in detention because the community was not able to provide the necessary treatment. In the USA, petty crimes, such as drug offences, can also result in the detainee getting a life sentence, whilst in Germany, they can access detoxification therapy, which is lacking in the USA (Subramanian & Shames, 2013:14), as well as in South Africa and Nigeria. What is clear from the above, is that the mentally ill are associated with the commission of violent crimes that are triggered by certain factors and as a result, are detained in the corrections system. Global information on other types of crime committed by those in detention in corrections is very limited, if there is any at all.

It is often asked whether correctional systems of the world encompass an environment that will promote and reinforce the changed rehabilitative efforts that

bring about positively changed behaviour of mentally ill detainees (Rössler, 2006:153). Research has also shown that the environment does play a role in mental illness and offending. Factors in the environment that are toxic to the mental development of an individual, and which results in mental illness, include substance abuse, troubled childhoods, unemployment, unstable family relationships, poverty, and even a low educational background, all of which can make an individual prone to mental instability. This is in support of the finding that the proportions of detainees with mental illnesses were meaningfully higher in low- and middle-income countries as compared to developed countries (Deady, 2014:3; Fazel & Seewald, 2012:367).

All the countries studied support the statement that mentally ill detainees are more prone to commit acts of criminality during incarceration. This could be due to the medication effects; erratic behaviour that arises from their non-comprehension that their actions may be detrimental to others; and their aggressive demeanour may incite threatening behaviour from other detainees which could result in assaults. These types of situations would therefore create a more stressful environment for the correctional staff, and threaten the administration of the facility and the safety of other detainees (Blevins & Soderstrom, 2015:145-146).

7.2.5 A Proposed Model for the Management of Mentally Ill Detainees in a Correctional System

Salize et al (2007:6) are of the view that literature is just too scarce to begin a serious discussion on models of best practice. Finding one model that fits all requirements is highly improbable; however, there are common aspects or practices that could be absorbed into mental health management in corrections. Authors have cautioned that mental health care and treatment is integral to community mental health care, and there should not be a detached set of rules for mental health care in corrections (Rich et al., 2014:464). Standards simply cannot be dropped and obstacles that currently create the differences between correctional and community health care must be reduced if correctional health care is to improve.

Figure 9 below, is a simple model that the researcher has developed that may assist corrections in the management of their mentally ill detainees. The purpose of this is to fill in the gaps that have been identified in the literature. The process excludes the judicial processes and does not form part of the discussions here. Important issues are highlighted and administrative processes are not discussed.

7.2.5.1 Requirements for the proposed model

7.2.5.1.1 Facilities

First and foremost, for effective rehabilitation, treatment, and care of mentally ill detainees, corrections must have facilities that will talk to this need.

Each detention facility under corrections must have a psychiatric unit which caters for the accommodation of mentally ill detainees. This must be located as a separate unit/building to that of the general population of detainees. This is to decrease any form of discrimination or stigmatisation of the mentally ill detainees.

Second to this, there must be a treatment department, or alternatively a step up unit which consists of units that are designed specifically for the rehabilitation and treatment of mentally ill detainees.

7.2.5.1.2 Human Resources

Each facility must have the appropriately trained personnel in mental health care and treatment (psychiatrist, psychologists, social Worker, and mental health care nurses). Even the security personnel must have a basic qualification on mental health if they are to be posted at these psychiatric units. Security personnel must be trained to react safely and efficiently to disorderly and hostile patient behaviour, without the use of weapons and other security equipment (Department of Health Services [sa]). Refresher training is also advisable on a continuous basis and should be applied uniformly.

7.2.5.1.3 Admission

At admission, the detainee enters the detention facility with a warrant for committal at the facility. Immediate screening within six hours should take place using reliable and valid screening tools which must be applied uniformly. If there is a suspected mental disorder or signs of suicidal behaviour, the detainee must be sent to the psychiatric assessment unit. Here a comprehensive assessment using standardised, valid, and reliable, tools must be used. All rehabilitation and security role-players must be in attendance for this comprehensive assessment including the psychiatrist, medical doctor, psychologists, and mental health nurses.

If the detainee comes in with a court order for therapy, the detainee must still be assessed to detect any critical issues such as a suicidal tendency, or other rehabilitation needs.

7.2.5.1.4 Sentence plans/treatment plans

As has been recommended, the drawing up of the sentence plans must comprise a multidisciplinary team and must include the detainee and a community member from the community that was wronged. The setting of rehabilitation targets would allow detainees to be responsible towards their rehabilitation goals. In as far as the community member is involved, it is important that countries which still follow cultural practices with regard to mental healthcare should also include these aspects as part of the treatment. They would also play a very special role in the step-down units, as corrections prepare the detainee for release into the community.

7.2.5.1.5 Treatment units – also called step-up units

The step-up units will have to accommodate the various mental disorders and be custom-built. The services that would be offered here cover the range of services from early intervention services through to intense inpatient treatment for the severely mentally ill. This will minimise the reliance on outside professionals to

administer their services. The inclusion criteria and policy for this must include the kind of diagnosis, typical length of stay offered, types of services being offered (eg. medical, clinical, educational, psychosocial etc), and service provider (eg. government, private, community-based service provider, church-based etc.) (Ngo, Ennals, Turut, Geelhoed, Celenza & Wolstencroft, 2020:2). It is preferable that all staff working in this step-up unit are Department of Corrections employees. Even at the step-up section there will be a separate unit to treat and care for the more seriously mentally ill detainees.

As suggested by Salize and Dreßing (2005:155), patients in these units are tended to by a ward team that includes specialists from various disciplines with special forensic training. Forensic psychiatrists and psychotherapists work together with forensically trained nursing staff, social workers, and occupational therapists. The services offered here must be in line with the sentence plan which must continuously be monitored and progressed checked against the targets.

The programmes and services offered at these step-up units are in line with the Department of Health, and specific to the mental disorder, but also for the holistic development of the detainee, and they may include psychological rehabilitation and therapeutic programmes - individual and group psychotherapy, family therapy, addiction therapy, psychotherapy, group therapy, occupational therapy, art therapy, music therapy, addiction therapy, athletic training, and team sports. Milieu therapy, aims to find stability in the detainee's life by providing a stable, controlled threat-free environment especially if the mentally ill detainee is coming from a chaotic background (Salize & Dreßing, 2005:155). Patients with severe disorders are placed in specialised treatment rooms for a limited time as is practiced in Germany. Forensic psychiatrists need to ensure that the criminogenic needs are also addressed.

7.2.5.1.6 Serving the sentence

In some countries, such as Germany, detainees who were partially responsible for the crime, and who are seen as a danger to the community, are given an

indeterminate sentence, and a determinate sentence to those who were fully responsible for their actions.

The “mentally ill” detainees will be reassessed for transfer to the correctional centre to serve their sentence once he/she has completed the treatment of their mental illness, and has been cleared by the psychiatrists to serve his/her sentence. Here the security personnel will assess the risk, in order to approve appropriate accommodation. The detainee must be sent where there is a non-overcrowded unit to allow the detainee to gradually adjust to life in detention. Cuéllar et al (2015:27) caution that 70% of maintenance programmes are not continued once the detainee enters the detention facility to serve his/her sentence. One must understand that there needs to be continuous maintenance therapy for continual preparation towards the sentence expiry date or parole consideration. Medication-taking must continue.

The time spent in the treatment facility must be subtracted from the sentence. The length of time deducted can be determined by each country and determined through policy. Best practices in Austria, show that all of the time spent in treatment is counted towards the sentence, whilst in the Netherlands, it can be up to two thirds (Salize & Dreßing, 2005:47).

7.2.5.1.7 Preparation for Release: Social Reintegration Unit

Six weeks before an detainee’s parole date or sentence release date (if sentence is such that the detainee was sentenced to imprisonment without parole), the detainee must be attended to by the Social Reintegration unit to prepare the detainee for release/parole. This would include contacting employment agencies, families, support groups, and psychiatric hospitals. It is imperative at this stage to determine whether the affected detainee can function independently in the community. It not, and if the mental illness still poses a challenge, then it is imperative to link up with an external treatment facility and support systems in the community (family and others).

7.2.5.1.8 Step-Down Unit

Once the mentally ill detainee has received their intense mental health treatment and other rehabilitation programmes at the step-up units, they must be sent to step-down units which are still managed by the Department of Corrections in partnership with the Department of Health but based in the community under the control of the Social Reintegration office. Only criminally responsible detainees that have served their sentence should be admitted into these units. The services that would be offered here are low intensity programmes in preparation for community life as an individual that has been rehabilitated and able to function independently. Step-down units are imperative to close the gap that has been identified as existing between corrections hospital-based inpatient care and the clinical community-based mental health support. These step-down units aim to provide a stepped care approach to ensure that mentally ill detainees receive the support that corresponds to their level of need and clinical care at the right time (Ngo et al., 2020:2). A memorandum of understanding must be developed to outline the roles, responsibilities, and working relations with the local clinical mental services if these services are to be outsourced to them. These step-down units will give the detainee sufficient time and space to recuperate and recover from their mental illness as well as participate in life skills reintegration services. These life skills reintegration programmes will give them perspectives and insights into transformations and developments in the community and skill them to adjust appropriately. These reintegration programmes also serve to build their confidence and to adjust socially such that it will lessen their urge to commit crime (Ngo et al., 2020:8-11).

Studies by Obioha (2011) have shown that contact with the detention institution creates more hardened criminals who will revert to committing crime and will ultimately lead to an increase in recidivism. One of the aims of these step-down units must be to ensure that these detainees do not have access to the more hardened criminals. The transition from the psychiatric wing/hospital to the prison to serve his/her sentence must be unwavering. There would be no need for the mentally ill who are recovering, to be exposed to a hard, cold environment, but they should rather be confined to an environment that supports their rehabilitation

from their mental illness. Step-down units must be designed to accommodate this. The approach that Germany employs, with regard to imprisonment itself being the punishment, should be the motto for these units.

The rehabilitation programmes offered in corrections must be appropriately balanced with psychiatric programmes in order for the detainee to be developed holistically. It is also a good idea to afford mentally ill detainees an opportunity to do tasks in the detention facility industries, or even work in some, so that they can earn an income that they can use upon release.

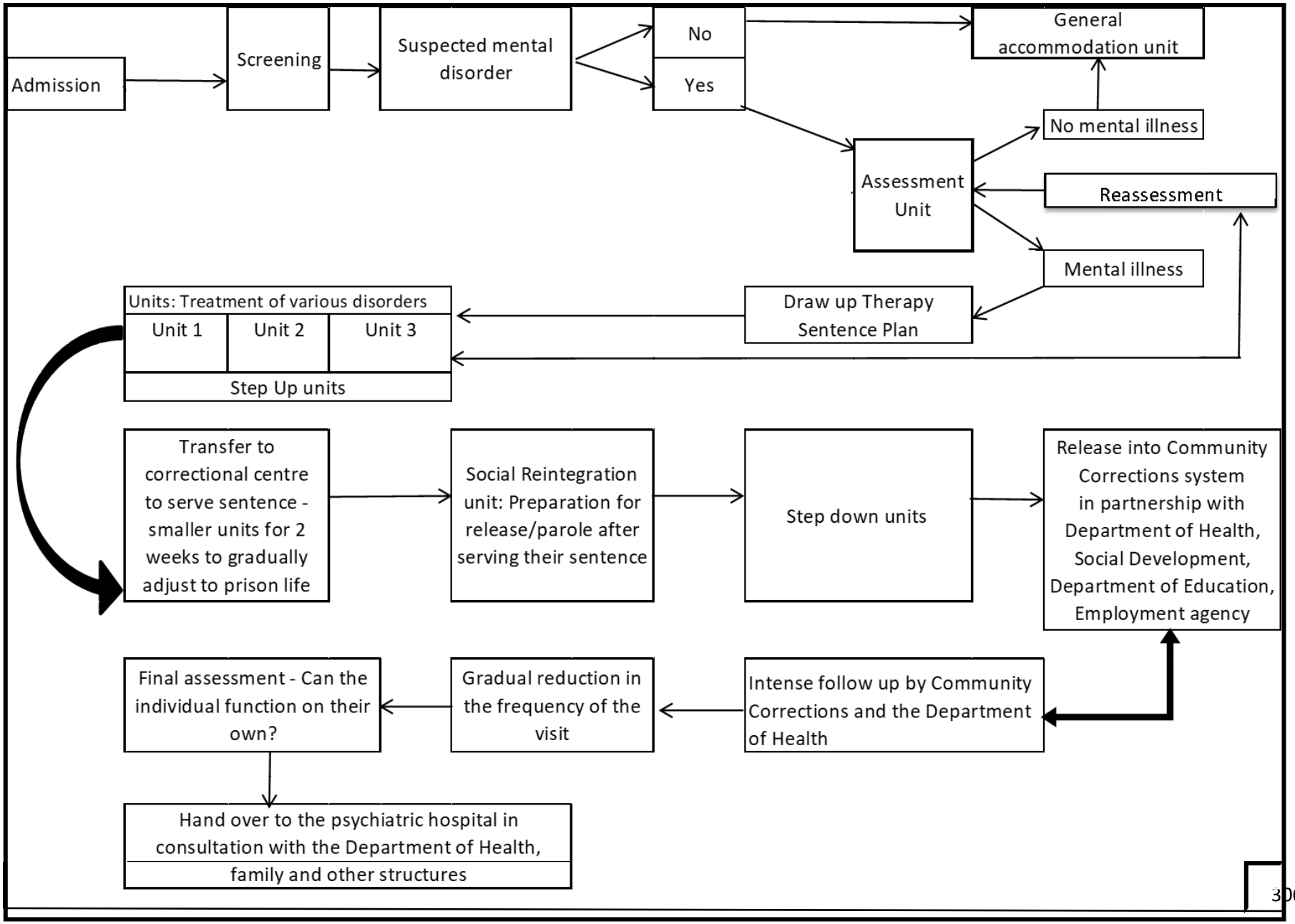
7.2.5.1.9 Release into the community

The affected detainee is now ready to be released into the community. Follow ups must be done for a period of time and gradually decreased to less frequent monitoring by a nurse with mental health qualifications. These follow ups must be regulated, uniformly applied, and legislated. These visits are to ensure that the affected detainee is coping, he/she is taking the medication (medication continuity), and that treatment is continued, if this was a condition, and other monitoring conditions. Should the monitoring officer reach a conclusion that the affected detainee cannot cope, and still requires further intervention, then they must be referred to the community psychiatric hospital run by the Department of Health.

It was initially mentioned that the services offered by corrections mental health should be no different from those of the community, so the transition from corrections step-down units to a public psychiatric hospital would be fairly easy and without major challenges. It must be noted that all information systems at the corrections step-up and step-down units must be linked to that of the Department of Health (of course having to consider accessibility to such information), so there would not be any need to resubmit documentation from one institution to another. Access to this confidential information via protocols can be arranged with the departments concerned.

On completion of the affected detainee's parole period, a final assessment in collaboration with the Department of Health must be done before the detainee is handed over to the Department of Health. The consideration for release from the community corrections system would lie in the final assessment's finding of whether the affected detainee can function on his/her own, and without a threat to his/her and others' safety, and whether his/her support structures are in place to provide the necessary support. It must be understood by all role-players that the Department of Health should be responsible for managing the mentally ill in the country, and that they play a pivotal role in all stages of the process.

Figure 9: A Proposed Model for Mental Health in Corrections



7.3 LIMITATIONS

The key restriction of this research, was that limited studies were in the public domain in South Africa, Nigeria, and in Germany. Studies in the USA were available from various sources, although a cross-sectional study is not available for a national overview for jails, state, and federal facilities. Because of this, findings from the various studies were generalised to the countries studied. Studies cited were heterogeneous in nature across all four countries. This resulted in the researcher deciding on an expansive definition of “detention” and “mental illness” to provide a complete and inclusive perspective on this poorly studied field (Lovett et al., 2019:37).

The terminology of detainees, detainees, inmates, and detainees are used interchangeably when referring to those detained in the corrections system. It is for this reason that the researcher used the terminology as it appears in the source that was consulted, and clarification is given when required.

The researcher is an employee of the Department of Corrections and has access to information that is presented at conferences, meetings, and in-house discussions. However, the documentary analysis approach taken by the researcher suggests that only documents availed to the public could be sourced/utilised.

The definition of recidivism has been defined for the purposes of this study, however it was difficult to compare recidivism rates in each country because each country defines it differently, and refers to it differently, such as re-conviction rate, re-arrest, relapse, re-imprisonment, and re-incarceration amongst others (Otu, 2015:136).

The countries also measure recidivism by different time lengths, for example, the USA measures this as a return within three years (Subramanian & Shames, 2013:6). In South Africa, the study by Morgan and Del Fabbro (2018:2) indicates that recidivism was calculated from any time of admission, and in the study by

Naidoo and Mkhize (2012:32), there was no indication on the length of time to calculate the recidivism rate of 21,7%. The study by Chukwudi et al (2019:12356) in Nigeria, speaks to a “few months after release”, and Germany looks at all people given a sanction by a court, not only those whom are released from the corrections system (Subramanian & Shames, 2013:6).

Furthermore, recent statistics for recidivism among mentally ill detainees in South Africa were not available. However, the study by Naidoo and Mkhize in 2012 at the Durban Westville Correctional Centre found the recidivism rate to be 21,7%, but this finding cannot be generalised to depict a national recidivism rate, since the Department of Correctional Services recognises that it does not have a system in place to measure this (Department of Correctional Services, 2005:74). The rate of recidivism in Nigeria in 2005 was 37,3%, while it escalated to 5,4% in 2010 and to 60% in 2015 (Otu, 2015:137). In Germany, Köhler et al (2009:214) found the recidivism rate to be 46,3% in their study on juveniles, and it was 21,6% in the study by Siefert and Möller-Mussavi (2005:16). The study by Zgoba et al (2020:4), conducted in 2013, found that the re-arrest, re-conviction, and re-incarceration rates were 52,3%, 38,2%, and 29,8% respectively. The risk of re-offending defines the degree and extent of the service that is provided to the mentally ill (Trestman et al., 2007:232).

7.4 RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made.
Of the four countries studied, Germany has shown as a country that their emphasis on “rehabilitation and normalisation” will have lessons for management of the mentally ill in South Africa, Nigeria, and the United States of America. Although South Africa has changed its strategic objective to include rehabilitation, it is not backed by the personnel and appropriate resources to successfully reach its goal. The U.S. criminal justice system and that of Nigeria must change their focus from punishment to rehabilitation, particularly for non-violent detainees (Deady, 2014:4).

It is evident that corrections must be able to balance the provision of rehabilitation programmes with that of treatment programmes for three reasons. Firstly, so that they are equally effective for the rehabilitation and/or improvement in the mental state of the detainee. Secondly, this balance is a requirement for the detainee's reintegration into society, and thirdly, for the protection of the public (Morgan et al., 2012:39). Rehabilitation programmes and treatment programmes must be modified to address unlawful and aggressive behaviour, which ultimately is one of the specific aims of correctional treatment programmes (Morgan et al., 2012:39).
The ideal practice would be to enforce legislation that mentally ill detainees should not be detained in corrections, but be that as it may, it has been found that they still continue to enter the corrections system. In Germany, mentally ill serious detainees are sent to a forensic psychiatric hospital to get the necessary treatment for their mental health before they serve their sentences. In South Africa, state patients and those waiting for observation are sent temporarily to the corrections system to await beds, and only if beds are available are they transferred to forensic psychiatric hospitals. Nigerian law had made it obligatory to send the "lunatics" to be "cared for" in prison, and the USA's mental courts serve to divert the mentally ill to community-based treatment and state forensic psychiatric hospitals (Lowder, Rade & Desmarais, 2018:15). Despite the mental health courts deciding on mental health matters in the USA, many mentally ill detainees enter the corrections systems, because not all states recognise mental illness as a defence, particularly the state of Kansas, with its truth-in-sentencing laws and minimum sentencing laws (Johnston, 2013:152).

It is recommended that Nigerian legislation be reviewed to incorporate current developments in the managing of mentally ill persons and in particular mentally ill detainees. Both Nigeria's Lunacy Act of 1958 and the Sharia Penal Code do not take into consideration the human rights and dignity of mentally ill individuals, as the mentally ill individuals are subjected to physical punishment. The Sharia Penal Code allows for states to administer penal sanctions, that are in contradiction to Section 34(1) of their 1999 Constitution, by subjecting them to "torture or to inhuman or degrading treatment", in the form of physical violence and "cautery" as therapy for psychiatric patients (Bello, 2013:28; Tzeferakos & Douzenis, 2017:2).

The issue of the mental health of detainees must be taken seriously by governments. It is recommended that there should be an unambiguous and uncomplicated mental health policy especially for detainees with mental health needs. Nigeria and South Africa has a dearth of such policies although the DCS policy on health obliges the DCS to develop mental health programmes to address the unique needs of the aged population (Department of Correctional Services, 2000:7).. The discussions have clearly shown that the management of mentally ill detainees are guided by the various codes, acts, and regulations, such as mental health regulations, health laws, and penal codes, and these are spread amongst various stakeholders, albeit some in a disorganised way. Current legislation has been derived from ancient laws for mentally disturbed detainees and have been regularly revised and modified over time to reflect continually progressive national legal or penal systems (Salize & Dreßing, 2005:237). It is therefore recommended that acts, codes, and existent policies, all need reviewing and constant updating to incorporate advancements in forensic psychiatry and the relentless advancement of mental health care systems (Salize & Dreßing, 2005:6).

It has been established that mental health disorders may also affect a detainee's likelihood for rehabilitation (both rehabilitation from the disorder as well as reforming the detainee). Mental illness must be detected as early as possible in order for the professional staff to start at the earliest opportunity with the rehabilitation/sentence plans. It is therefore imperative that proper screening and detection of mental illness at admission be conducted by personnel qualified in the field of mental illness. Germany and the USA use varying screening and assessment tools which can create issues with the varying approaches required to treat and manage mental illness. It is recommended that federal screening and assessment tools be availed to all states with a legal obligation to utilise the tools. This may level the playing fields regarding treatment.

In addtion, it is recommended that all personnel of the Department of Corrections, including role-players in the CJS, be provided with appropriate training in early detection of mental illness, as well as in the handling of such cases from the time of arrest to the release, either from the mental institution or the corrections system (including those in community corrections). Continued training must be provided to

cater for changes in legislation and policies. Training must also focus on sessions that will include, amongst others: the clinical expression of psychiatric illnesses; skills required to care for detainees with psychiatric disorders; life skills; communication skills; and how to relate professionally and empathetically with detainees who have such susceptibilities; early detection of potential to commit suicide; skills in suicide prevention; administering medication; and medication monitoring (Posholi, 2019:59). Training of security personnel on types of mental disorders, treatment, and care will improve their understanding of mental disorders and ultimately assist them to treat the mentally ill appropriately and humanely (World Health Organization, 2003:4). It is therefore vital that corrections management make provision in their planning to train both the security and health staff on mental health issues.

It has been established that there is a shortage of professional staff in the corrections system to effectively treat and care for mentally ill detainees. According to Blevins and Soderstrom (2015:145), appropriately qualified mental health professionals are not eager enough to work in the corrections environment, and this is one of the reasons for the inferior quality of mental health provisioning in corrections. It is recommended that the Ministry of Health, together with the Ministry of Justice, approach this methodologically and find ways of attracting individuals to the mental health profession, especially in the correctional system. A corrections system simply cannot afford to function without psychiatrists, and the lack of psychologists in corrections must be addressed. Attracting them to these professions is just not enough – ways must be found to retain them in the field. Further to this, it is also recommended that professionals (both private and state) in medicine, nursing, mental health, criminologists, psychologists, social workers, counsellors, and related disciplines be obliged as part of their professional and social responsibility to avail their services regularly and as often as they can to prisoners and detainees. This will be more applicable in South Africa, Nigeria, and in the USA, as it is established that Germany does not imprison mentally ill detainees.

It is therefore recommended that the norms used by tertiary institutions, and as determined by the relevant professional boards, must be re-evaluated to include a

bigger intake of those wanting to pursue a career in psychology and in psychiatry. It is blatantly clear that this profession lacks its professionals.Overcrowding, as well as related problems such as lack of privacy, can also cause or exacerbate mental health problems, and increase rates of violence, self-harm, and suicide (Penal Reform International, 2020). Corrections, alone, cannot solve the issue of overcrowding, as it is more than just a facilities issue. Overcrowding must be addressed using a multidisciplinary approach. It needs the entire criminal justice role-players' involvement, including criminologists, lawyers, medical doctors, mental health practitioners, and psychologists, amongst others. It has been established that remand detainees make up a significant part of the detainee population (in some cases more than 30%). Many of them are in detention for long periods of time due to slow processing of their cases in the CJS, thus continuing to add to the already overpopulated detainee population. It is therefore also pertinent to reconsider the cases of awaiting trial and address the backlogs (Stephens, 2018:348-349).

If mentally ill detainees continue to be detained in the corrections system, then it is suggested that corrections should enforce and monitor the multi-disciplinary approach that is documented. This must be done to resolve the multi-faceted challenges being faced with the management of the mentally ill in corrections. These challenges do not occur because there is no legislation nor guidelines, but because these guidelines are not operationalised. Therefore, professionals from the rehabilitation components (psychology, sociology, education, mental health, general medicine, counselling, theology, social work) as well as facilities planning, security, and external non-governmental agencies, must plan holistically for the needs of mentally ill detainees. High recidivism rates are a warning sign that corrections and the CJS as a whole are unsuccessful in correcting the rebellious and disruptive (antisocial) behaviour of detainees (Otu, 2015:137). Many factors cause recidivism. These include, amongst others: environmental factors; historical discrimination and stigmatization by society; insufficient reintegration programmes; lack of support systems in the community; family issues; substance dependence and/or abuse; and peer influence. It is therefore recommended that, as in the case of Germany, corrections authorities must include the detainee and the community leader of the community he/she offended to be a part of developing the sentence

plans and treatment plans. This would give the detainee a role to play in his/her rehabilitation and may lead to a commitment to follow that plan. It is also recommended that the rehabilitation programmes must be accredited and approved by medical councils or the relevant bodies and maintained by all other staff members that come into contact with mentally ill detainees. It has been established that quality medical attention for mentally ill detainees and providing them with rehabilitation programmes such as education and vocational training are foremost recidivism-control strategies (Otu, 2015:136).

The major limitation of the study highlighted is the fact that studies cited were not conducted at a national level, and the researcher had to use these findings to generalise about the whole country. It is therefore recommended that national studies should be conducted for one to be able to provide a more comprehensive national comparison that would provide a greater wealth of information on prevalence rates of mental disorders among the various detainee populations (Naidoo & Mkhize, 2012:34). This would enable a detailed comparative analysis between them.

Proper provisioning of mental health care starts with legislation. Critical issues, such as respecting the rights of all detainees to basic healthcare, non-exposure to torture and discrimination, providing care and treatment of a quality that is parallel to that of the community, can be addressed by legislation (World Health Organization, 2003:9). Moreover, policies must focus on practical and realistic strategies to enable effortless transitioning and reintegration of detainees with mental disorders into the community. Countries must ensure that treatment methods used, must be culturally sensitive, especially in culturally-rich countries like Nigeria.

The researcher recommends that future research should focus on exploring the effect that COVID-19 has had on the mental state of the incarcerated population and how the pandemic was managed.

Legalised measures employed by various countries to prevent detainees entering the corrections system range from diverting mentally ill detainees out of the CJS

by referring them to treatment facilities, acquittal on grounds of mental impairment or released under conditions as found fit by the courts (correctional supervision) or even released unconditionally (Stevens, 2013:12). The researcher suggests that judges must consider other options available instead of detention in corrections, with the aim of effectuating "proportionate punishment" to avoid "over punishment". Available options might be house arrest, electronic monitoring, correctional supervision, fines, or being ordered to have treatment. Another option that could be to include a residential placement condition in a community treatment order (Dawson & O'Reilly, 2015:524). This is done in Ontario, where consent is given for a mentally ill person to "reside in a group home or residential setting which, by program design, supports the development of life skills and promotes treatment adherence" through residential orders (Dawson & O'Reilly, 2015:524). However, the ultimate decision must be based on what is best for a mentally ill detainee in terms of his/her treatment and care. Johnston sums it up befittingly when he states,

> "Only by treating an offender differently (i.e., by recognising his susceptibility to serious harm) will he be treated equally (i.e., similarly to those without major mental disorders who are equally blameworthy)".
>
> (Johnston, 2013:151)

7.5 CONCLUSION

The research conducted covers a wide range of topics. This was done so that mental illness could be understood from a broader perspective and for one to understand the cross-field dynamics involved in managing mentally ill detainees in corrections.

It has been established that mental illness in corrections is a health problem that could be better managed. Mentally ill detainees do not belong in the corrections system. However, it has been shown in the literature reviewed that the community provisioning for the mentally ill is also under-resourced and inadequate. However, the mentally ill are sent to the corrections system, either to wait for beds to be

made available by the community health care system, or because they are criminally responsible, either fully or partially, and therefore must serve their sentences. In some countries, many mentally ill detainees who have committed petty crimes or no crimes at all are sent to corrections detention facilities, and many more remain undetected in the system. This being the case, they cannot be left to languish in the corrections system with little or no access to treatment and proper care. Proper treatment and care are imperative to end the cycle of returning to incarceration.

One has to give meaning to legislation by implementing it. There is incongruence between the policy and the practice. This calls for a radical plan of action that would involve all role-players, specifically governments, to ensure that these vulnerable people are managed appropriately within appropriate facilities and with the appropriate personnel and expertise. This radical plan of action must start by addressing the social ills in the community.

Policy must address issues that would guarantee the safety of the mentally ill detainee, and all staff and service providers, whilst considering the safety of the public. At the same time, rehabilitation programmes, and specifically psychiatry treatment programmes, must be administered in a facility that is ready and designed for such programmes. Until that becomes the norm, mentally ill detainees should not be detained in corrections.

The challenges outlined, such as staff shortages; inappropriate facilities; ineffective record keeping thus the dearth of data and statistics; lack of funding; stigma; no access to treatment programmes; minimum sentencing rules; overcrowding and its related challenges; all must be addressed to ensure that mental health protocols in corrections are of an acceptable standard. The role of security and rehabilitation staff working together cannot be overemphasised. There must be a balance among all involved to progress towards integrating the mentally ill detainee into the community. Further to this, overcrowding and over utilisation of facilities remains a challenge, which impacts on operational strategies, service delivery, and meeting strategic objectives (Department of Correctional Services, 2018b:13).

The Department of Corrections on its own cannot successfully address the mental health crisis behind bars. They need the assistance and active participation of community groups and other government departments. Literature reviewed is clear that it is a matter of poorly planned policies as it pertains to deinstitutionalisation, reduced funding for public mental health services (Kupers, 2015:123).

In effect, governments, with the input of society, must decide whether mediocre treatment of the mentally ill in all facets of their lives is good enough, or whether it must be dealt with the seriousness it deserves. It cannot be allowed that individuals with serious mental illnesses are arrested and sent to corrections where dreadful and harmful detention conditions would exacerbate their mental illness. Central to all decision making, must be the advocacy of their rights, in an effort to address the ill effects of “isolative confinement” and violence used against mentally ill detainees (Kupers, 2015:123).

The researcher is of the opinion that should the recommendations be considered, then this could pave the way for better management of the mentally ill in the corrections system.

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ETHICS APPROVALS

UNISA university of south africa

UNISA CLAW ETHICS REVIEW COMMITTEE

Date 20180910

Reference: ST89 of 2018
Applicant: R Naidoo

Dear Mrs Naidoo

Decision: ETHICS APPROVAL
FROM 10 SEPTEMBER 2018
TO 9 SEPTEMBER 2021

Researcher(s): Rishidevi Naidoo

Supervisor(s): Dr FCM Louw
Prof C Cilliers

The management of mentally-ill detainees in the correctional system: A comparative study

Qualification: PhD (Criminal Justice)

Thank you for the application for research ethics clearance by the Unisa CLAW Ethics Review Committee for the above mentioned research. Ethics approval is granted for 3 years.

*The **negligible risk application** was reviewed by the CLAW Ethics Review Committee on 10 September 2018 in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment. The decision was ratified by the committee.*

The proposed research may now commence with the provisions that:

1. The researcher will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the CLAW Committee.
3. The researcher will conduct the study according to the methods and procedures set out in the approved application.

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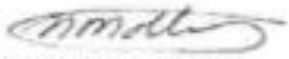
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data requires additional ethics clearance.
7. No field work activities may continue after the expiry date of 9 September 2021. Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ST89 of 2018 should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.

Yours sincerely,



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Ms R Naidoo
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Dear Ms Naidoo

RE: APPLICATION TO CONDUCT RESEARCH IN THE DEPARTMENT OF CORRECTIONAL SERVICES ON: "THE MANAGEMENT OF MENTALLY ILL DETAINEES IN THE CORRECTIONAL SYSTEM: A COMPARATIVE STUDY"

It is with pleasure to inform you that your request to conduct research in the Department of Correctional Services on the above topic has been approved.

Your attention is drawn to the following:

- This ethics approval is valid from **13 March 2019 to 12 March 2022.**
- You are required to use the terminology used in the White Paper on Corrections in South Africa (February 2005) e.g. "Offenders" not "Prisoners" and "Correctional Centres" not "Prisons".
- You are required to submit your final report to the Department for approval by the Commissioner of Correctional Services before publication (including presentation at workshops, conferences, seminars, etc) of the report.
- Should you have any enquiries regarding this process, please contact the DCS REC Administration for assistance at telephone number (012) 307 2770.

Thank you for your application and interest to conduct research in the Department of Correctional Services.

Yours faithfully

ND SIHLEZANA
DC: POLICY COORDINATION & RESEARCH
DATE: 15/03/2019